# Assessment of the HIV situation in selected sites in Kyrgyzstan, Uzbekistan and Kazakhstan

## *Recommendations for Interventions*

Prepared for USAID/Regional Mission for Central Asia

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Gina Dallabetta
Director of Technical Support/Prevention
HIV/AIDS Prevention and Care Department

Sergey Gavrilin
Consultant

IMPACT/Family Health International

Impact Implementing AIDS Prevention and Care Project

## Executive Summary

Based on current limited information, Kyrgyzstan and Uzbekistan appear to have low level HIV epidemics (defined by UNAIDS as having less than 5% prevalence of HIV infection in all groups) and Kazakhstan appears to possibly have a concentrated epidemic in certain locations (defined as having and HIV prevalence of over 5% in high risk groups but under 1% in the general population). These countries all have a significant number of individuals with high-risk behaviors making them vulnerable to HIV infection such as injecting drug users (IDUs) and female sex workers (FSWs). While the current efforts to reduce risk behavior have shown successes they have limited scope and coverage. **Expanded HIV prevention efforts are now needed to avert a significant HIV epidemic in these countries.**

The national institutions in these countries that have responded to the STD and HIV/AIDS situation are staffed with talented and motivated people struggling under numerous constraints including:

- Lack of full understanding by policy makers and decision makers about effective interventions to address the increasing numbers of HIV infection in IDUs and to address the risk in FSWs and other groups.
- Local non-governmental organizations (NGOs) and governmental institutions (GIs) working with these high-risk populations have limited capacity to design, implement and evaluate HIV/AIDS prevention programs.
- Limited resources
- There is limited coordination/communication/sharing among groups in HIV/AIDS prevention, especially across disciplines.
- HIV, STD and behavioral data on these populations are inadequate, limiting program design and information for advocacy.

It is recommended that HIV prevention activities targeting high-risk group be expanded substantially and efforts be made to simultaneously develop sustainable and effective capacity in HIV prevention activities. This will require strengthening existing individuals and institutions, and working to create and strengthen country and regional networks of groups working in HIV prevention. The areas of focus should include: outreach and service delivery to vulnerable groups, personnel, organizational capacity development, information technology, communication, training, and education. Specifically, the following actions are recommended:

- Support the implementation of targeted prevention interventions in high-risk groups. Based on the current epidemiology of HIV infection, the IDU populations in the general community and in prisons/detention centers should be given top priority. FSWs are also at risk and require interventions.
- Support the development and implementation of comprehensive behavioral and biologic surveillance plans to monitor HIV/AIDS and sexually transmitted diseases (STDs) for program planning and advocacy.
- Support the work of UNAIDS and other key stakeholders to refine the national HIV/AIDS strategic plans.
- Increase coordination, communication and planning among groups working in HIV/AIDS across the region and support the development of technical support systems through systematic, structured and ongoing technical support that would further develop the capacity

- Support the technical and organizational capacity building of individuals and groups (GIs and NGOs) to design and implement comprehensive HIV prevention programs for high-risk populations. Areas of assistance would include:
    - HIV prevention implementation skills – strategy, design, report writing, implementation approaches and management and organization skills. This can be accomplished through technical assistance, NGO "twinning", national and regional workshops to increase skills, and participation in international meetings and other fora.
    - Participatory planning to ensure participation of target populations in the design and implementation of programs;
    - Establishment of client friendly services for at risk populations, especially those that focus on STD case management, family planning (including for HIV positive individuals and discordant couples) and HIV VCT;
    - Strengthening formal linkages and referral systems to services (especially STDs, family planning, HIV VCT, TB and HIV care and support);
    - Comprehensive behavior change intervention programming for IDUs that more effectively integrate drug, sexual, HIV VCT and HIV care and support;
    - The continuum of counseling from community-based peer counseling to HIV VCT to professional-led sexual and substance use/abuse counseling; and
    - Monitoring and evaluation and the use of data for programming and advocacy.
- Work with governments and other stakeholders to address cross-border and regional issues.

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***Abbreviations***

| | |
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| AIDS | Acquired Immunodeficiency Syndrome |
| BCC | Behavior Change Communication |
| BSS | Behavioral Surveillance Surveys |
| CAR | Central Asian Republics |
| CDC | Centers for Disease Control |
| CIS | Commonwealth of Independent States |
| ELISA | Enzyme-Linked Immunosorbant Assay |
| FHI | Family Health International |
| FSW | Female Sex Worker |
| HBV | Hepatitis B Virus |
| HCV | Hepatitis C Virus |
| HIV | Human Immunodeficiency Virus |
| HR | Harm Reduction |
| HSS | HIV Surveillance Surveys |
| IDU | Injecting Drug Use |
| IMPACT | Implementing AIDS Prevention and Care |
| KAPB | Knowledge, Attitude, Practice, Behavior |
| MOH | Ministry of Health |
| MSF | Medecins Sans Frontieres |
| MSM | Men Who Have Sex with Men |
| NGO | Non-governmental Organization |
| NIS | Newly Independent States |
| OSI | Open Society Institute |
| RAR | Rapid Assessment and Response |
| RH | Reproductive Health |
| RPR | Rapid Plasma Reagin |
| STD | Sexually Transmitted Disease |
| STI | Sexually Transmitted Infection |
| TB | Tuberculosis |
| TPHA | *Treponema pallidum* Hemagglutination Assay |
| UNAIDS | United Nations AIDS Program |
| UNDP | United Nations Development Program |
| UNDCP | United Nations Drug Control Program |
| UNDCOP | United Nation Organization on Drug Control and Crime Prevention |
| UNFPA | United Nations Family Planning Association |
| US | United States |
| USAID | United States Agency for International Development |
| VCT | Voluntary Counseling and Testing |
| WHO | World Health Organization |

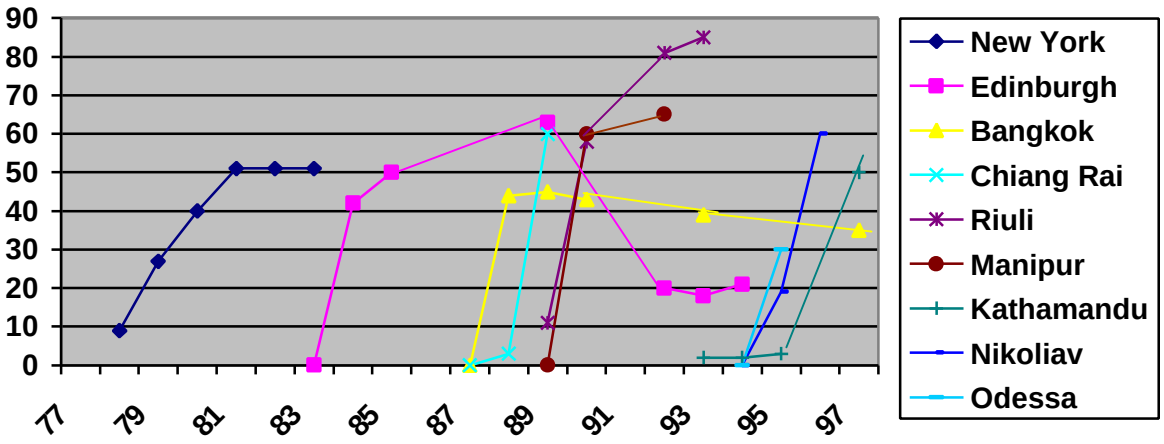
# I. Introduction

This report responds to the request by the USAID/Central Asia Regional Mission to do an assessment of where USAID could best respond to HIV prevention in the Central Asia Republics (CAR) and to suggest gaps in knowledge in order to plan effective interventions. The purpose of this initial assessment was to assess data gaps, contextual and policy constraints, and implementing and collaborating groups, and to make recommendations regarding prevention interventions in three cities/regions - one each in Kazakhstan, Kyrgyzstan and Uzbekistan. This assessment was performed in January 2001.

# II. Background

## A. HIV/STD Epidemic in Eastern Europe

***Figure 1: Rapid increased in HIV prevalence among IDUs, 1978-1998***




The example of the HIV explosion in Eastern Europe, including Ukraine, Russia and Belarus of the newly independent states (NIS), illustrates how quickly the HIV epidemic in injecting drug users (IDU) can expand. The cumulative numbers of HIV cases reported in the Eastern European region increased between 1995 and 1997 from 9,111 to 46,573, a five-fold increase in just 2 years. Ukraine, Russia and Belarus accounted for about 90% of all new cases. Two thirds of these infections were believed to have occurred in 1997 alone. Injecting drug users accounted for the majority of these reported HIV cases, from 49% to 85% of the total. Additionally, the number of reported syphilis cases has risen sharply in the countries of the former Soviet Union highlighting the increased vulnerability of the general population to further spread of HIV via heterosexual intercourse. Based on 15 years of experience in HIV infection in IDU populations, it is estimated that once HIV prevalence among IDUs reaches 10%, it can surpass 40 to 50% within 1 to 4 years (see Figure 1). The HIV epidemics in IDU populations have occurred quicker

than an appropriate policy and HIV prevention interventions responses can be developed once HIV appears. The lesson from these 15 years of observation of HIV epidemics in IDUs is that prevention interventions in IDU populations should be instituted early before HIV appears.

## B. Theoretical Framework and Lessons Learned for Proposed Approaches

*A low prevalence strategy – focusing on core groups*: HIV epidemics in all countries have started and subsequently flourished in at least one or more of the following groups – female sex workers (FSWs), IDUs or men who have sex with men (MSM)—before spreading to the general population. HIV prevalence rises first in these groups and then gains a critical mass, which allows the epidemic to be sustained and spread. The converse is also true and critical for the planning of prevention resources -if HIV prevalence can be kept low in such core population groups, then it will not attain a critical mass to spread to the general population in any significant amount.

This process of epidemic spread strongly supports a focus on core-transmitter and "bridge" populations groups whereby prevention resources are targeted to changing their behaviors with the goal of keeping HIV prevalence low. If successful in these core groups, resources directed at larger population groups will be minimized. Historically, interventions directed at general population groups are more costly, less efficient and less effective. The strategy advocates for concentrating resources on the so-called "high transmitter" population groups which ultimately protects the whole population through the efficient use of resources in an early, concentrated HIV epidemic setting. HIV/AIDS prevention activities with these high-risk groups must be carefully crafted in order to target these high-risk groups but not stigmatize them.

The effectiveness of any HIV/AIDS program requires the development of an environment that will support effective risk reduction interventions and behavioral changes among high-risk groups. This refers to the context in which risk behaviors take place and the factors that tend to sustain or inhibit them. These include social, political, economic and legal factors, as well as stake holders (e.g. pimps, and police) who may control access to beneficiary groups and who may influence or control their ability to adopt safe practices.

### *1. IDUs*

HIV infection in IDUs is transmitted by micro-transfusion of blood through multipurpose use of needles and syringes, other preparation paraphernalia such as cookers, cottons, rinse water, and in certain settings the preparation techniques. Consequently, as a guiding principle of interventions to reduce HIV transmission in IDUs, one needs to identify high risk, high density situations and promote reduced sharing of equipment. Such situations include shooting galleries, drug sellers injecting equipment, prisons and jails, and group injecting.

IDUs in most of the world are threatened not only by their behavioral risk, but by a societal response that denies and ostracizes drug use and uses a predominantly punitive model coupled with limited treatment facilities. A comprehensive strategy to address HIV infection in IDUs has a foundation is a harm reduction approach. This approach is a staged approach of making drug

injecting safer by (1) reducing and eliminating sharing of drug injecting equipment, (2) reducing the frequency of injecting through detoxification and rehabilitation to drug substitution approaches, and (3) stopping drug use all together. The guiding principle of this strategy is based on international lessons learned in keeping HIV prevalence low in IDU populations. These lessons recognize and stress that drug use itself does not cause HIV infection, neither does even drug injecting, but that sharing of contaminated drugs and drug equipment is the major risk factor for rapid HIV spread. The harm reduction approach gives drug users options of reducing their risk at various levels and focuses on supportive, rather than punitive strategies. The approach recognizes that while stopping drug use is often the ideal goal, several intermediate goals such as safer injection techniques and drug treatment (including drug substitution therapy) are just as helpful in reducing HIV infection. A full discussion of harm reduction can be found in the *Manual for Reducing Drug Related Harm in Asia* and other publications (see references).

The implementation of a harm reduction approach consists of:

- *Gaining support of policy makers and stakeholders (nationally and locally)*
- *Penetrating the social networks of IDUs in community locations where they frequent and meet*. This activity is best and likely solely accomplished by members of the target group. Successful interventions have used the peer-mediated approach model sometimes called network leaders, peer-education, gatekeeper access
- *Establishing an effective outreach team and potentially establishing drop-in centers to better access IDUs.*
- *Building a peer-driven program whereby IDU network leaders are involved in the actual planning and implementation of harm reduction program and condom promotion.*
- *Creating necessary linkages to drug treatment and substitution programs where they exist, HIV counseling and testing, and primary health services.* Clear and explicit links between the existing HIV VCT centers should be made to take advantage of the proven prevention benefits which quality HIV testing and counseling can produce. Linking prevention messages with care services often enhances the prevention messages – the "care-prevention synergy". Linkages with drug substitution and rehabilitation programs are also important as they belong in the typical harm reduction hierarchy of (1) reduce the sharing of injecting equipment; (2) reduce the incidence of injecting (drug substitution therapy); and (3) reduce drug use (drug treatment and rehabilitation). Many drug users want to stop drug injecting and stop drug use all together.

Environmental interventions for IDUs to support harm reduction are essential because of the sensitivities surrounding IDU interventions. Supportive policy and community environments are necessary for effective interventions to occur. This includes support both at the national level as well as at the local level from community groups and local law enforcement agencies. Finally, as indicated above, the active involvement and participation of IDUs in the design and implementation of interventions are vital for success. IDUs should not to be considered passive

***The experience with "prevented" HIV epidemics in IDUs is most relevant for CAR. Characteristics of these prevented epidemics included:***

- ***starting early,***
- ***providing adequate supplies of sterile injecting equipment, and***
- ***using community outreach.***

recipients of services but instead must be viewed as playing a vitally important role in the prevention of HIV/AIDS.

HIV epidemics in IDU populations are now being categorized as (1) saturated (2) stable high seroprevalence, (3) prevented, and (4) reversed. Saturated epidemics are defined as HIV prevalence of 80% or more in the populations. Interventions in this group should be directed at preventing sexual transmission of HIV, caring for HIV infected and preventing new susceptibles from entering the population. Stable, high seroprevalence HIV epidemics have been, through aggressive interventions, able to maintain HIV prevalence at around 30 to 40% of the population. These interventions have been able to show a decrease in reported needle sharing. "Reversed" HIV epidemics in IDUs have also been documented. In New York for example, HIV prevalence has declined from around 50% to 20%. As a result of interventions there has been a decline in receptive needle sharing to about 20%, a decline in distributive sharing among HIV-infected IDUs, increase participation in syringe exchange and increased participation in HIV voluntary counseling and testing (VCT) from 40 to 76%. In addition to these documented decreases in individual risk, there has been a reduction in high-risk settings and a loss of HIV-infected persons as a result of disability and death. Given that the HIV epidemic is only just beginning in the CAR with the IDU populations, the experience with "prevented" HIV epidemics in IDUs is most relevant for CAR. "Prevented" epidemics in IDU populations are defined as populations where HIV prevalence remains under 5% for at least four years. There are examples of prevented epidemics in Glasgow, Scotland; Lund, Sweden; Tacoma, Washington; and Sydney, Australia. Characteristics of these prevented epidemics included (1) starting early, (2) providing adequate supplies of sterile injecting equipment, and (3) using community outreach. Also, from ongoing behavioral assessments in these populations, it is clear that sharing injecting equipment is still occurring, but the prevalence of the high-risk settings such as shooting galleries is markedly reduced. Less effective IDU interventions (1) do not attract participants (user hostile vs. user friendly), (2) have too low a dose of the effective agent (too few syringes, no rehabilitation after detoxification), (3) are of insufficient scale to have any impact, or (4) are overwhelmed by changes in drug use patterns (must have ongoing monitoring and evaluation). HIV can enter IDU communities because drug users may travel for social or economic reasons, drug users travel along drug distribution route, drug tourism does occur in some parts of the world or HIV may be introduced from non-IDU populations, through sexual transmission for example.

***Ineffective IDU interventions***

- ***do not attract participants***
- ***have too low a dose of the effective agent***
- ***are of insufficient scale to have any impact, or***
- ***are overwhelmed by changes in drug use patterns (lack ongoing monitoring and evaluation).***

### *2. Sex Workers and Their Clients*

In any society including the CAR, most STD transmission occurs within a relatively small segment of the population characterized by high rates of sexual partner change. Vulnerability to infection based on high levels of exposure, combined with frequent opportunities to transmit infection to others, make effective prevention and treatment strategies for such groups a priority. Clients of sex workers usually come from larger, more heterogeneous groups that are more

difficult to identify and access. Certain male occupational groups, e.g. transport and migrant workers, and uniform services, may have frequent contact with sex workers. Because male core groups also have contact with lower risk women, e.g. wives and girlfriends, they act as a bridge carrying infection from high prevalence core groups to the general population (and are referred to as "bridge groups").

Reaching the most vulnerable individuals with effective services is not always a simple task. Sex workers and others with the greatest number of sexual partners are often socially marginalized, discriminated against and, most significantly for control efforts, may be the last persons reached by traditional care services. In addition, even where access to preventive and curative care is good, standard management approaches are often not sensitive enough to detect most infections.

Additionally the distinction between commercial sex workers and clients has practical applications when considering intervention strategies. Sex workers are usually highly aware of the risks implicit in their profession and can often be approached and identified where they do business. On the other hand, clients of sex workers tend to be more secretive and are often reached more easily through indirect routes, such as places of employment or STD services.

Peer education has been shown to be a powerful approach to outreach that emphasizes empowerment of vulnerable risk groups and encourages group solidarity and adoption of positive group norms.

Special clinical services are needed to address the unique needs of these 'core' populations. In order to maximize impact, therefore, targeted approaches to STD control require attention to:

- *Outreach* – how to reach the target population
- *Service delivery* – how to set up and provide services
- *STD management strategies* – how to detect and treat STDs

***Outreach:***

Arguably the most critical step in implementing effective targeted interventions is reaching the core groups and convincing individuals of the value of the intervention. Simply setting up services will not necessarily result in people using them. An important principle is the involvement of core group members from the start in the design and implementation of services. Members of the target population are in the best position to define aspects of service delivery that are important to those being served.

Peer education has been effectively used to organize groups of sex workers, raise awareness about STD and other health issues, and promote preventive behavior and use of curative services. High levels of condom use and declining STD rates have been reported from longstanding peer programs in Zimbabwe and Kenya and brothel-based interventions in Thailand. Addressing the wider range of health and safety issues within a human rights framework will ensure active participation of marginalized groups such as sex workers.

Based on numerous global examples, outreach is often best accomplished by target group members themselves -a peer-outreach approach. Linkages with specific services such as clinical services, education, or child-care, allow these outreach groups to offer more comprehensive services to the target population. Coordination between clinical service groups and community groups is essential to ensure mutually reinforcing messages.

Reaching male bridge populations involves different approaches. Examples that have been successfully used include:

- Condom promotion and prevention messages targeting clients at bars and brothels
- Employee health programs (transportation industry, migrant workers and military)
- In STD services (after presumed exposure to high risk partners)

***Service Delivery:***
Once peer educators have been trained and are raising awareness about STDs and how to treat and prevent them, the demand for curative services will likely increase. Two important issues to consider in setting up or adapting curative services are accessibility and acceptability. Accessibility is influenced by such factors as distance to services as well as convenient hours of operation. Sex workers are unlikely to use services that are far away and open only during hours when they are working or sleeping. Acceptability issues include respect for privacy and confidentiality, non-judgmental attitudes of staff and perceived competence of care providers. The more accessible and acceptable the services, the more likely they will be used. On-going involvement of the target group in the design and implementation of these services will ensure that they meet the needs of the population.

Improving accessibility to STD services for sex workers may include:

- Arranging clinic sessions in fixed site clinics during convenient hours
- Organizing special static clinics
- On-site services in hotels or brothels
- Organizing mobile clinics
- Organizing and training private STD practitioners/physicians

Workplace clinics are a logical focus for providing preventive and curative STD services. Where work conditions separate workers from their families, STDs might be considered an occupational hazard requiring the same attention to preventive and curative services. This is true both for men away from home but also young women migrating to work in women dominated industries (e.g. the garment industry). Programs might include a strong prevention emphasis as well as periodic screening (for example, prior to home leave) in addition to readily accessible, non-judgmental services for symptomatic individuals.

***STD Management Strategies:***
Once special services have been organized to meet increasing demand, decisions must be made about which strategies are appropriate for detecting and managing STDs. If outreach and peer education components are successful in reaching persons with the highest rate of partner

changes, and services are sufficiently accessible and acceptable to attract them, STD management strategies will need to be capable of managing the STD service needs of the target populations, e.g. specific STDs and frequency of re-infection.

## C. Drug Issues in the Central Asia Republics

Opium production in Afghanistan has increased considerably since the mid 1980s. The raw opium product was traditionally exported to Pakistan and to heroin laboratories in Turkey through Iran. All countries surrounding Afghanistan introduced the death penalty for drug trafficking, except Tajikistan in the north. In the mid 90s increased security measures in Iran and continuing unrest in Tajikistan resulted in the redirection of the main drug traffic routes northward, through Tajikistan, Kyrgyzstan or Uzbekistan to Kazakhstan and ultimately to Russia and Europe. This northern route seems to be the most attractive for drug traffickers at the moment. Large-scale heroin production facilities have been opened in Afghanistan in the north, close to the Tajikistan border. As a result all the traditional raw opium has been gradually replaced with heroin, although some stock of raw opium still remains in the CAR. It is estimated that at the beginning of 2001 Afghanistan has 300 tons of heroin ready to be exported though the central Asian republics destined for Europe and Russia. Kyrgyzstan, a county with a population of about 5 million, has 200 officers working in the Drug Control Department of Police. In the year 2000 they detained over 1,500 kilograms of opiates (mainly opium and heroin), a small fraction of the total narcotics transported through Kyrgyzstan. It is likely that the quantity of illicit drugs seized is below 5% of the total transiting the country. The situation in Uzbekistan is likely similar as Uzbekistan has a longer border with Tajikistan.

***All indirect and direct evidence indicates that the main drug trafficking goes through the Fergana valley then northwards.***

All indirect and direct evidence indicates that the main drug trafficking goes through the Fergana valley then northwards. One route is through Bishkek to Almaty to northern Kazakhstan (Astana, Pavlodar and Kostanai), and on to Russia. The other route goes through Uzbekistan to western Kazakhstan and north to Russia and Europe. Khorog is a town located on Afghanistan border: drugs from this town are transported on the only road to Osh, Kyrgyzstan, the first city on this road in the Fergana valley. This was the main drug trafficking route. Increased security measures on the Khorog-Osh road, undertaken on the Kyrgyz-Tajik border, by all drug enforcement departments and by frontier troops has forced drug traffickers to reroute their product through the rest of Tajik northern borders, especially the Batken area in the south-west of the Fergana valley. It is reported that at present drugs are mainly smuggled by couriers on horses and on foot through 'paths' along the whole Tajik border, destined towards bigger settlements: Osh and Batken, and further to Bishkek and Fergana oblast in Uzbekistan. During the last two years there has been a continuing war on Kyrgyz side with rebels known as "vahhabits", a branch of Islamic extremists. The vahhabits have political claims against Karimov, the President of Uzbekistan, and are attempting to destabilize the situation in the whole area. Kyrgyz officials are inclined to think that the main reason for the uprisings is securing a drug route through Kyrgyzstan and Uzbekistan. In any case, Kyrgyzstan fights with vahhabits every year losing dozens of soldiers. The generally unfriendly Uzbek-Kyrgyz relations further complicate the situation.

Afghanistan produces about US$45 billion worth of drugs annually. Possible transit/export of drugs through the Kyrgyz territory might be as much as 30-35 tons. Almost half of the drugs are opiates produced in Afghanistan and destined for the CIS and West Europe. The amount of drugs detained increased 296% (heroin 8.8-fold, opium 8.3-fold times) between 1999 and 2000.

A portion of the drugs transported through the Central Asian countries is consumed locally. Easy access and the low price of opiates, especially heroin, could characterize the drug situation in the whole region. For example, in Osh City in the south of Kyrgyzstan heroin is available at the price of US$4 per gram wholesale. Retail price of a single dose (1/8 or 1/10 of a gram) bought from dealer in the same city could be as low as US$0.50-$1 depending on its quality. The current price of 1 gram of heroin in and around the Uzbekistan border is about 200 Som (~US$4.0 ). There is no reliable data about the drug availability and its price in Uzbekistan. However, it is very possible that the situation is similar in Uzbekistan, especially in Fergana oblast, adjacent to Osh oblast of Kyrgyzstan. Uzbekistan officials confirmed some information about the growing heroin consumption as opposed to 'traditional' opium consumption. In Kazakhstan, slight differences in the drug situation could be observed in geographically remote areas. However, the pattern is very similar for the whole of Central Asia (See Table 1).

Previously the most widespread injection drug was raw opium (*khanka*), raw juice collected from cuttings of poppy heads and (*khimka*) the same raw opium produced from the whole plant through a complicated chemical procedure. Ephedron and heroin were available but not widely used. However, in the last two years the situation has changed considerably. First of all, illegal drugs are increasingly more available and, secondly, traditional raw opium has been replaced with heroin. IDUs have been forced to switch to heroin because of the lack of availability of opium. Opium is still available in some areas of Kazakhstan and Central Asia, but if the trend continues it will be completely replaced with heroin, which is more cost effective to transport.

Smoking marihuana (*anasha*) and opium was considered a traditional practice in Asia. The Chui valley of the Central Asia was considered the biggest producer of high products made of cannabis. *Cannabis Sativa* or Indian hemp grown in the Chui valley and in various regions of CAR has very high tetrahydrocannabinol (THC) content. Most IDUs report that they progressed from smoking marihuana and hashish to injecting opiates. The average time between the inception of smoking drugs to starting to inject drugs is about 1 to 2 years. However, only a small percentage of people smoking cannabis based drugs switch to injecting. Recent reports indicate that heroin smoking as a first drug experience is increasing. Most heroin smokers switch to heroin injecting very quickly, within a few months, because smoking heroin becomes very expensive. Most of them report that their major motivation for switching to injection is economic.

Drug related specialists and surveys might mention the so-called 'traditional' consumption. This 'tradition' refers to smoking cannabis (anasha or marihuana and hashish) and opium. Indian hemp was cultivated in the Central Asia since the 19$^{th}$ Century for textile (jute bags). It has not been cultivated since the middle of the 20$^{th}$ Century, though it is now wildly growing in Chui valley, mainly in Kazakhstan. It can be found elsewhere in CAR, but the Chui valley is famous for its hemp forests. Smoking opium with a water pipe (kalian) is still in practice, especially in the Fergana valley in local 'mahallas' (communities). It should be also noted that Opium Poppy

was cultivated in Kyrgyzstan for pharmacology till 1974, mainly in the Issyk-Kul area. After the official cultivation was prohibited, illegal cultivation in the remote mountain areas continued. Drug enforcement officials have made ongoing efforts to eliminate this illegal cultivation. Most recently, opiates were traditionally consumed in small groups of three to five people. Larger groups were undesirable because (1) they were easier targets for police and (2) the size limited the number of people with whom the IDUs would have to share. The small group size is ideal when the drug has to be prepared, like raw opium. This fact and opium 'traditions' make IDUs gather in the same small groups, although there may be occasional newcomers to the group. However, heroin injection appears to be done either alone or with one or two persons. The long preparation process is not an issue with heroin. However, the risk of potential overdose makes users reluctant to inject completely alone.

The average age of IDUs is 22-30 years in the whole of Central Asia. However in recent years, consumption of illegal drug substances has been noted in younger and younger ages. Cases of injecting drug use and addiction, although rare, have been reported among children and teenagers.

***Up to half of all female IDUs earn money through commercial sex activities***

Women constitute a small proportion of the IDU population. In the entire Central Asia region women represent about 10% of the IDU population. In Bishkek, Kyrgyzstan, however, the percentage of women IDUs has been reported to be as high as 30%. Up to half of all female IDUs earn money through commercial sex activities. The number of IDUs among female sex workers (FSWs) is small but reportedly increasing; currently in Kyrgyzstan where the best data exists of the sites visited, IDU in FSWs appears to be less than 10%.

Table 1 summarizes selected information from seven UNAIDS sponsored Rapid Assessment and Response (RAR) analyses in the region and some additional information from this assessment's key informant interviews and document reviews. This information corroborates the details above. Of note, the table documents:

- The shift from opium to heroin in Kyrgyzstan between 1998 and 2000 and the shift to predominantly heroin in northern Kazakhstan.
- The predominance of males as IDUs, although there has been an increase in female IDUs in Bishkek
- That needle sharing is common
- The majority of sexual partners of IDUs are themselves ***not*** IDUs
- Where explored, the percentage of female IDUs engaging in commercial sex for income is high (16% to 50%)

**Table 1: Summary of UNAIDS Sponsored Rapid Assessment and Response Analyses and Other Data in the CAR region**

| Site | # Registered IDUs | Estimated number of IDUs | Drugs used | % IDUs who are male | % dividing dose from common container | % sharing needles | % sexually active (not defined) | % > 1 partner | % with non-IDU partner | % of females in commercial sex |
|---|---|---|---|---|---|---|---|---|---|---|
| **Uzbekistan** | | | | | | | | | | |
| **Tashkent (1998)*** | 757 | 12,000 – 15,000 | Opiates§ | 92% male | 96% | 94% | 88% | 70% | ">50%" | ---? |
| **Kyrgyzstan** | | | | | | | | | | |
| **Osh (1998)*** | 336 | 5,000 | Opiates (mainly) & heroin | 88% male | "almost always" | 90% | 90% | --- | --- | 33% |
| **Osh (2000)**** | --- | --- | Heroin 97% Opiates 3% | --- | --- | --- | --- | --- | --- | --- |
| **Bishkek (1998)*** | 1,763 | 14,000 - 15,000 | Opiates | 92% male | 73% (unregistered) | "common" | 90% | 10% | 75% | ~50% |
| **Bishkek (2000)**** | --- | --- | Heroin 97% Opiates 3% | 70% male | --- | --- | --- | --- | --- | --- |
| **Kazakhstan** | | | | | | | | | | |
| **Almaty (1998)*** | 1,083 | 11,000 – 12,000 | Opiates | 77% male | 77% | "common" | 90% | --- | 81% | ---? |
| **Shymkent (1998)*** | 783 | 20,000 | Opiates 91% Heroin 9% | 92% male | 92% | 98% | 80% | 70% | ">50%" | 16% |
| **Pavlodar (2000)*** | 1,463 | 8,000 | Heroin 90% Opiates ~ 10% | 90% male | 80% of opium addicts | 50% | 92% | 50% | 85% | ---? |
| **Astana (2000)*** | 1,446 | ---- | Heroin 60% Opiates ~40% | 85% male | "common" with opiates | 94% | 80% | 75% | 86% | ---? |
| **Kostanai (1999)***** | ~600 | 3,000 – 4,000 | Heroin 30% Opiates – 70% | --- | 73% (use blood – 9%) | 79% | -- | -- | --- | -- |

* UNAIDS Rapid Assessment and Response reports (see References)

** Information from UNDP/Soros Funded Harm Reduction Projects in Kyrgyzstan (personal communication SG)

*** Key informant interviews in Kostanai with Narcology Institute and the NGO *Public Fund Help*. Behavioral data cited are baseline.

§ Opiates refers to any of the various raw opium products available in the region, e.g. "koknar", "khanka", etc

? Reports cite "decreased moral and ethical norms" among female IDUs

# III. Country Profiles

This section will summarize relevant findings from the numerous reports of various organizations on their work with the proposed target populations, IDUs and FSWs. In addition it will outline what other donors and groups are doing or are planning to do in this area and identify the potential resources at each site.

## A. Kyrgyzstan

Kyrgyzstan has been implementing an HIV/AIDS/STD prevention strategy since 1997 with the technical and financial assistance of the UN Theme Groups on AIDS. The project has supported activities in a multi-sectoral approach to AIDS prevention involving both government and non-governmental structures. Current priority directions for the government include prevention programs for youth, commercial sex workers and IDUs. This assessment will focus on the latter two target groups. However, it is recognized that there are efforts being made to address youth.

### *1. Drug Use, including IDU*

The prevalence of drug addiction in Kyrgyzstan increased 5-fold between the period from 1991 to 1997, with an average growth rate of 25% per year. The highest prevalence rates were observed in the large cities. In 2000, the Kyrgyz Republic detained 5,180 kg of narcotics destined for illicit drug use. This compares to 600 kg of opium seized in 1995 and over 1,500 kg drug seized in 1997.

As of 1999, the total number of registered IDUs in the republic was 1,069**.** This represents a 6.2-fold increase in the number of registered drug users from 1991. It is estimated that the total number of IDUs in the country is about 50,000. The police records indicated over 80% of those detained for drug use had on their persons small doses of drugs (indicating users, not dealers).

The age of first drug consumption is decreasing. In the 1980s, first experience with drugs occurred at the age of 16 to 18 years and regular consumption started at the age of 20-22 years of age. In the late 1990s, the age at first use of drugs was estimated to be 13-14 years of age with regular use starting at age 15-16. There are reported but rare cases of drug dependence in children as young as 10-12 years of age.

***Osh:***

With funding from the Soros Foundation in Kyrgyzstan and UNDP, a harm reduction (HR) project was established in Osh (and in Bishkek) in late 1999. This pilot project dealt with public attitudes and perceptions through newspaper articles and television programming. It established a working dialogue with the police to address ongoing issues. The project, through the district committees, held regular educational sessions with the general public. The project employed 6 outreach workers, comprised of spouses of drug-users or former drug users, trained them and provided them with materials (i.e., syringes, needles, cotton, disinfectants, educational material

and, whenever possible, condoms). Working in pairs these outreach workers covered three different city districts. The outreach workers were able to overcome the initial skepticism of IDUs – "It is a trap", "They just want to register us" – such that the target of 210 IDUs was reached 8 months into the project (see Table 2). The outreach workers report that there is a large demand for needles and syringes in the IDU population in Osh and that they could easily increase participation with increased commodity supply. The project supplied higher quality syringes and needles than could be obtained in the commercial markets in Osh. Needles and syringes are widely available in the markets and relatively inexpensive. The outreach workers also report that it is known throughout Osh that sharing needles is not safe. Baseline and end of project behavioral data to the question "Do you use someone else's needle?" show a remarkable change in risk behavior. At baseline among 50 respondents, 80% responded "yes" to the questions. At the end of the project only 5% of 200 respondents answered "yes".

**Table 2: Summary of Harm Reduction Project Activities in Osh City, 2000**

| Month | Needles given | Needles collected | Syringes given | Syringes collected§ | Condoms given± | New clients | Total clients (number females) |
|---|---|---|---|---|---|---|---|
| **January** | --- | --- | 300 | 187 | 90 | 33 | 33 (5) |
| **February** | --- | --- | 1985 | 2070 | 150 | 37 | 70 (6) |
| **March** | --- | --- | 3900 | 3726 | 220 | 24 | 76 (7) |
| **April** | --- | --- | 5200 | 5231 | 288 | 26 | 90 (7) |
| **May** | 902 | 16 | 6552 | 6579 | 370 | 38 | 116 (12) |
| **June** | 2521 | 1105 | 6040 | 6283 | 144 | 44 | 109 (12) |
| **July** | 2154 | 1475 | 9839 | 9895 | 50 | 57 | 153 (12) |
| **August** | 1835 | 1407 | 11081 | 10887 | 40 | 25 | 210 (13) |
| **September** | 3283 | 2857 | 15130 | 13843 | 0 | 22 | 210 (15) |
| **October** | | | 13471 | 13286 | 0 | 17 | 210 (17) |
| **November** | 1150 | 620 | 14160 | 13794 | 0 | 15 | 210 (17) |
| **December** | 5070 | 4019 | 14137 | 13999 | 0 | 18 | 210 (17) |
| **Total:** | **17820** | **12459** | **104573** | **102329** | **1352** | **356** | **210** |

§ Syringe return rate averaged of 97.8%.
± Condom supply from UNFPA was limited.

The project also provides at the trust point psychological counseling, first aid for skin and wound infections and referrals to designated specialists for other medical issues such at STDs, TB and surgery. The project noted a dramatic decrease in the number of skin infections and abscesses

with the provision of clean injecting equipment and instruction on better injecting practices.

The project manager indicated that in the event of additional resources his priorities would be:

- Establishment of a rehabilitation center
- Expanded syringe exchange
- Increased interventions directed at commercial sex work
- Implementation of substitution therapy
- Prevention work in schools and among youth

He also noted that there was currently no prevention work done in either the detention centers or the prisons in Osh. He was interested in providing educational materials and disinfectants. All detained persons in Kyrgyzstan are tested for HIV infection. Unlike Kazakhstan and Uzbekistan, HIV infected prisons are not housed separately. [Note: UNDP and Soros/Kyrgyzstan are just beginning a pilot project in prisons in Bishkek. Policy dialog is currently underway with Ministry of Interior and prison officials].

Interviews with the outreach staff of the HR project and representatives of the target groups confirmed the keen interest of other IDUs in Osh to participate in the project and the satisfaction of the participants in the attention to their issues. The interviews also confirmed the project has ongoing issues with the police and police harassment. Some of the IDU participating in the HR project requested help with overcoming their drug addiction and were extremely interested in methadone maintenance and rehabilitation.

### *2. Female Sex Workers*

UNAIDS has supported rapid assessments of sex work in four cities in Kyrgyzstan – Bishkek, Osh, Tokmak and Issyk-Kul. In general, it appears that the sex work industry throughout most of the region is relatively unstructured and there is limited organized crime involvement (personal communication, G. Kurmarova). Most of the female sex workers come from rural areas. As a result they are poorly adapted to urban life and do not speak or read Russian. However, hey do have some reading ability in their own languages. Sex workers do not view themselves as professionals but have entered sex work as a temporary source of money. Roughly there are two types of female sex workers in Kyrgyzstan – street workers and those associated with a company/agency or other facilities such as saunas. Street workers have the lower pay levels of the two groups. The company based sex workers are more "professionalized" and receive higher pay. Reportedly, university students who enter sex work as a way to earn money generally use the company route; at this level female pimps are frequently involved.

***Bishkek:***
A project in Bishkek with funding from UNDP/UNAIDS, UNFPA and WHO has been implementing a FSW project for several years. This project provides education materials and outreach, condom promotion, and STD services. The project also involves efforts to change the

risk environment by promoting changes in public opinion of FSWs and addressing legal issues. It is estimated that there are about 2,500 FSWs in Bishkek falling into the general structure described above. In addition there are two brothels of about 20 women each. It is estimated that the street sex workers have about 2 clients per night. The project estimates that outreach workers cover about 70% of the street sex worker population in the city. About 10% of the sex workers are under the age of 18 years. A total of 30% have reported using narcotics sometime in the past. About 10% of FSWs in Bishkek are actively using drugs. As of early 2000 the team has seen a marked increase in reported use of heroin. STD prevalence is high in these sex workers – a first visit prevalence of syphilis of 16.1% and of gonorrhea of 7.8% has been documented. The project has documented an increase in condom use among FSW – in February 1998 about 13% reported using condoms and in October 2000 over 60% reported using condoms. The sex workers, however, report not using condoms with regular clients.

In evaluating the clients of female sew workers the project in Bishkek looked at 260 clients of street-based sex workers. The wholesalers in the bazaars and small scale businessmen (the so called 'shuttles') were by far the most frequent clients of the street-based sex workers. At a distant second and third were taxi and truck drivers and then government officials at all levels. The police are frequent users of sex workers but were not classified as clients since they do not pay and frequently rob and beat the sex workers. Military personnel are also frequent users of sex workers in areas where large numbers of military personnel are located. In research done by the same group operating in Bishkek soldiers were questioned about their use of commercial sex; 70% of the respondents indicated that they had had commercial sex contact in the previous year. The researchers also point out that there is likely is a significant amount of informal sex work in villages near military posts and truck stops.

***Osh:***

In Osh, Médecins Sans Frontières-France (MSF) has been working with female sex workers (FSWs) since 1997. Their approach consists of a "tripod" approach – outreach, clinical services and primary prevention. As is characteristic of the rest of the region, sex work is relatively unstructured (see Table 3).

**Table 3: Characteristics of FSW in Osh, Kyrgyzstan**

| Category of FSW | Average income per client | Percentage of total |
|---|---|---|
| **Street-based** | 80 – 200 com | 60-70% |
| **Sauna-based** | 100 com | 10% |
| **Hotel-based** | 40 – 50 com | 20% |
| **Telephone solicitation** | Expensive | Unknown |

FSWs reported 1 to 3 clients per day. A total of 51% of the FSWs have children and the vast majority are either never married or divorced. Of the 400 FSWs surveyed, the mean age was 23 years with a range of 13 to 52 years. "Madames" are mainly involved in the sauna-based sex work. Sixty percent are Kyrgyz, 30% are Uzbeki and 10% are other (Russian, Tartar, etc). Most have a limited education, mainly primary school. The main reported reason for entering sex

work was economic. It has been estimated that there is about an 80% rotation annually of FSWs in the area. Most of the FSWs in Osh do not have the appropriate papers and therefore cannot access medical care. MSF estimates about 5% of FSW in the Osh area are IDUs. There is an increase in oral and rectal sex attributed to the European pornography films. FSWs report that clients ask for "European sex". Police harassment and police extortion of FSWs are common.

MSF supports a drop in center where they educate the FSWs on various topics, distribute condoms and provide outside speakers in various areas (lawyers, FSWs from Bishkek, physicians). Women in need of medical services are referred to outside physicians contracted by MSF to provides services such as –STD, gynecology, pediatric, maternity, surgical and detoxification services. MSF has also begun outreach to potential clients of sex workers including taxi drivers, truck drivers and porters in the bazaar. Reportedly, the police have not been terribly receptive to educational efforts by MSF to date.

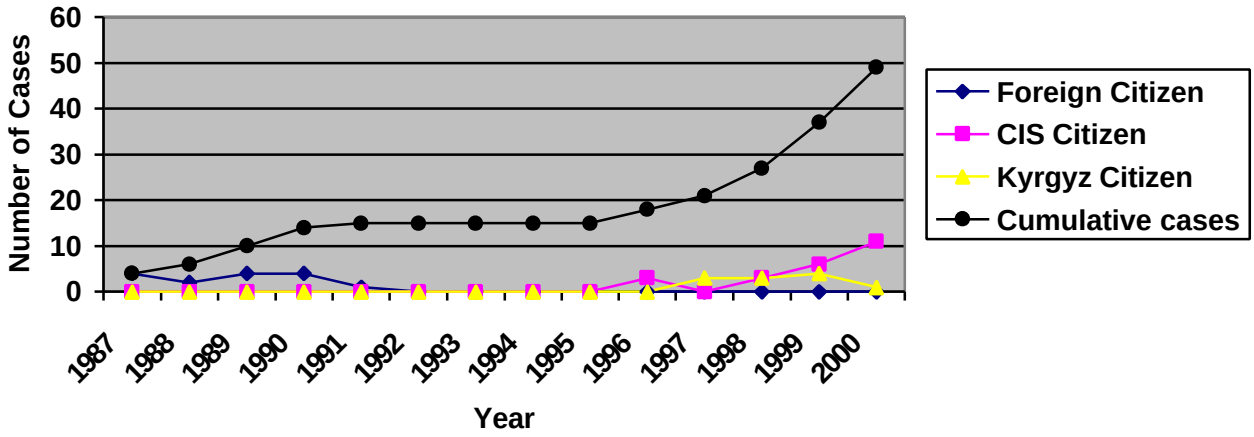
### *3. HIV Situation*

***Excluding the 15 African HIV cases identified in the early 1990's, the majority of HIV infections in Kyrgyzstan are attributed to IDU.***

As of mid 2000, a total of 49 HIV infected persons have been identified. The breakdown of these cases by place of origin includes 11 Kyrgyzstan citizens, 38 foreigners (15 Africans identified in 1987-1991, 16 from Russia, 4 from Ukraine, 2 from Kazakhstan and 1 from Uzbekistan) (Figure 2). The vast majority of the total HIV infection is reported in men, 43 (88%). Among the 11 Kyrgyz citizens with HIV infection 6 (55%) are men. Excluding the 15 African HIV cases identified in the early 1990's which were all attributed to heterosexual transmission, the majority of HIV infections in Kyrgyzstan are attributed to IDU; 18 of the 23 CIS citizens (78%) and 6 of the 11 (55%) Kyrgyz citizens fall in the risk group of IDU. A total of 3 (13%) of the CIS citizens and 4 (36%) of the Kyrgyz citizens with HIV infection are classified as heterosexual transmission and the remainders are classified as unknown.

Surveillance for HIV infection in the Kyrgyzstan Republic now targets high risk groups while the total number of HIV tests done in the country is decreasing from about 890,000 in 1991 to about 162,000 in 1999. In the year 2000 a total of 2,719 IDUs were tested (registered IDUs and walk-ins) and 17,890 STD patients were tested. Other groups targeted for testing include blood donors (Dr. Shapiro estimates that 98% of blood is screened), people with irregular sexual relations and men who have sex with men (MSM).

**Figure 2: HIV infection in the Kyrgyzstan Republic**




Based on reported prevalence data in IDU populations, the HIV epidemic situation in Kyrgyzstan is unclear. Based on a UNAIDS classification, Kyrgyzstan is either a nascent (early) HIV epidemic (prevalence of HIV infection is less than 1% in all groups) or a concentrated epidemic (HIV prevalence is over 5% in high risk groups but less than 1% in general population). The IDUs participating in the Soros and UNAIDS funded HIV prevention activities in Bishkek and Osh were tested for HIV in May 2000 and again in October 2000. The results are listed below in Table 4.

**Table 4: HIV prevalence in IDU in needle exchange program in Bishkek and Osh**

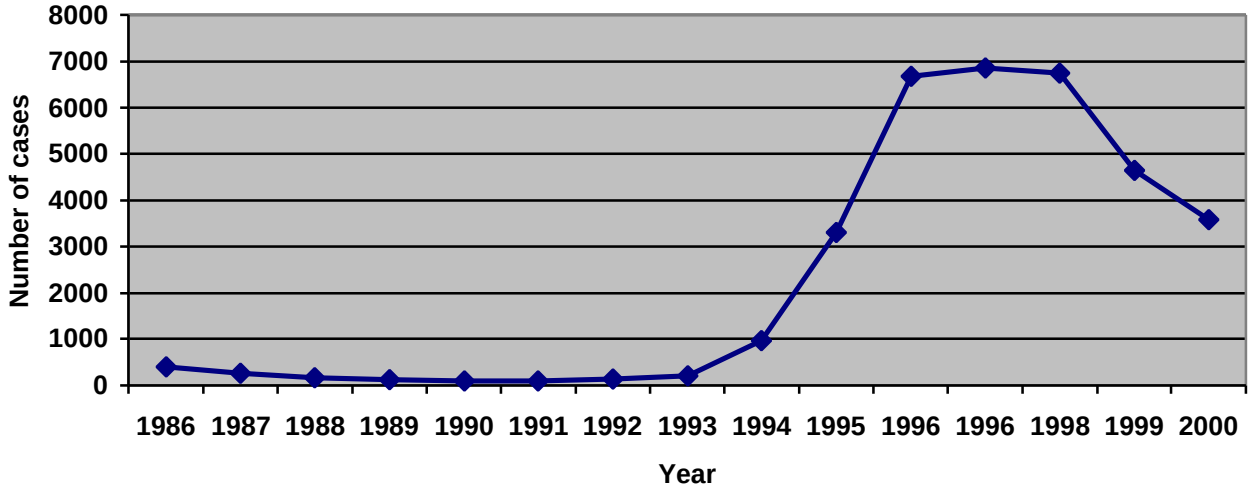
| | **May 2000** | **October 2000** |
|---|---|---|
| **Bishkek** | 11.5-18.5% (n~275) | 0% (n~250) |
| **Osh** | 32.2-49.8% (n~86) | 0% (n~200) |

The wide discrepancy in these HIV prevalence figures may be due to the fact that the first testing was done on residual blood left in syringes turned in by the participants, resulting in poor quality samples (for example, bacterial overgrowth and haemolysis due to long delivery time in the summer heat), laboratory error or poor performance of test kits. During the workshop on Epidemic Surveillance for Osh medical personnel working with IDUs, following the first HIV testing (June 2000) specialists of Bishkek AIDS Center retested blood from the same IDUs. This time blood was delivered very quickly; 90 samples showed two positive results and another 2 samples were in determinant. The second round of HIV testing took place in October, when the weather was cool. Project workers were instructed to bring syringes with blood remaining in them to the AIDS center as quickly as possible. These samples were handled expeditiously to get to the testing laboratory. Of 450 samples tested none were positive. Repeat HIV testing of these intervention populations is scheduled for the spring of 2001.

### *4. STD Situation*

Similar to other countries of the CIS, Kyrgyzstan has experienced a rapid increase in reported syphilis cases. Between the years of 1990 and 1997 there was a 77-fold increase in reported syphilis cases in the country as a whole and in Bishkek the increase was 140-fold (see Figure 3). It is estimated that only about 60% of syphilis cases are reported. Congenital syphilis cases are also increasing, from 0 in 1994 to 12 in 1995, 45 in 1995 to 67 in 1998, 93 in 1999 and 53 in the first 20 months of 2000. A total of 53.2% of syphilis cases have occurred in the age group from 20 to 29 years of age.

**Figure 3: Reported cases of syphilis in Kyrgyzstan**




***Osh:***

MSF provides STD services through subcontracted gynecologists, venerologists and general practitioners. In 2000, MSF provided services to 15,375 STD patients, about 8,900 women and the rest men. Among these patients there were 4,419 cases of cervicitis, 1,073 cases of urethral discharge and 1,001 cases of reactive syphilis serology.

MSF has worked with local and national officials to develop STD treatment guidelines for their services. They have recommended a locally adapted syndrome management approach to the common syndromes. In addition, they have concurrence that syphilis will be managed on an outpatient basis, they have changed the protocol for STD treatment to be one or three injections of Benzathine Penicillin depending on the syphilis stage, and have instituted the inclusion of quantitative Rapid Plasma Reagin (RPR) and confirmatory *Treponema pallidium* hemagglutination assay (TPHA) to the syphilis testing protocol that now only includes a Wasserman test. While MSF will be implementing this protocol in Osh, nationwide implementation will take time and training [personal communication, Dr. Yves Marchandy]. MSF also conducted a gonococcal antibiotic susceptibility study on 120 strains obtained in Osh between January 1999 and April 2000. As expected there was high-level resistance to penicillin for 26% of the strains and to tetracycline for 33% of the strains. A total of 25 % of strains show

an intermediate level of susceptibility to the quinolone class of antibiotics while none of the strains show high-level resistance. A total of 2 percent of the strains show an intermediate level of susceptibility to third generation cephalosporins; no high level resistance to 3rd generation cephalosporins was observed. All of the strains, 100% were susceptible to spectinomycin.

### *5. Current HIV prevention activities*

**UNAIDS:**
- Supporting HIV/AIDS strategy development and policy dialog
- Supported RAR among drug users in Osh and Bishkek and a situational assessment of commercial sex industry in Bishkek, Osh, Tokmok and Issyk-Kul
- Provides technical assistance for HIV/AIDS prevention activities
- Provided training for health care providers
- Supports a FSW intervention in Bishkek

**UNDP:**
- Supported the development of a multi-sectoral approach to HIV/AIDS prevention activities
- Supported Harm Reduction projects among IDUs in Bishkek and Osh
- Supported the procurement of HIV diagnostic equipment
- Supports a FSW intervention in Bishkek
- Supports harm reduction in prisons (prevention information and disinfectants) with Soros/Kyrgyzstan

**WHO:**
- Supported HIV diagnostic equipment
- Supports a FSW intervention in Bishkek

**UNFPA**:
- Provided support for safe sex projects throughout the country
- Provides condoms (continuing supplies unclear)

**UNESCO:**
- Provides support for truck driver prevention projects

**UNDCCP:**
- Supported information and education project among IDUs
- Provided training to law enforcement, youth and others
- Supported the publication of materials

**Soros/Kyrgyzstan:**
- Supporting harm reduction interventions in Bishkek, Osh and Chui-Tokmok
- Supported pilot school projects on health
- Supports harm reduction in prisons (prevention information and disinfectants) with UNDP

**USAID:**
- Within current health reform project supported prevention activities around Issyk-Kul, supported training of health care providers and publication of prevention materials. Additionally with WHO they supported a demonstration project implementing STD treatment in primary health care clinics.

**MSF-France:**
- Supporting youth sexual health project in Osh
- Supporting comprehensive FSW intervention in Osh
- Provides STD training to physicians and free STD treatment though this network.

**UNDCP:**
- Supporting an upcoming comprehensive situational assessment of drug use in the five countries of central Asia.

### *6. Summary Findings*

- Drug use and injecting drug use appears to be increasing dramatically in the country.
- Excluding the highly suspect prevalence figures from the May 2000 Soros assessments, the HIV epidemic in Kyrgyzstan appears to be a low level epidemic with IDUs being the major risk group.
- Females appear to be an increasing proportion of IDUs. Some female IDUs turn to commercial sex for income.
- There appears to be small scale but good quality interventions for both IDUs and sex workers in the two major cities in Kyrgyzstan, Osh and Bishkek. For example, the IDU intervention in Osh directly supports 210 of an estimate 5000 IDUs, under 5% of the population.
- There is little surveillance data outside of registered IDUs and the small cohorts participating in the current harm reduction program in Bishkek and Osh.
- STD rates in FSWs are high.
- STD rates in IDUs are unknown.
- Reported syphilis cases appear to be decreasing.
- Interventions with clients, male bridge populations, are limited.

## B. Uzbekistan

### *1. Drug Use, Including IDU*

In Uzbekistan, there are 12,000 medically registered drug users and about 12,000 registered for prevention. However, it is estimated that the total number is likely 5 times this number, or about 60,000. UNDCP estimates that there are about 100,000 drug users where drug use includes alcoholism and other drug use in addition to IDU. A UNDP and UNAIDS 1998 RAR estimated at total of 12,000 – 15,000 IDU in Tashkent. It is estimated by the UNDP office that less than 10% of the IDUs in Uzbekistan are female and that 40 to 50% of the female IDU engage in

commercial sex.

As a result of documented high numbers of HIV cases among IDUs in Tashkent and Yangi Yul the Ministry of Health of Uzbekistan issued a decree (a "prikaz") to establish 50 trust points (needle exchange points) that would provide information about HIV/AIDS; distribute syringes, needles and disinfectant; and distribute condoms. UNAIDS in collaboration with the Tashkent city government organized three trust points as pilots and provided the condoms and syringes. UNDP/UNAIDS is providing syringes to all of the trust point sites but admits that financial constraints would likely preclude them from meeting increasing demand. UNDP/UNAIDS supplied the clinics with 5cc Becton-Dickenson needles with 26-guage syringes – supplies that are nearly impossible to obtain in Uzbekistan and the type of supplies specifically requested by the IDUs. Syringes of variable quality are widely available and relatively inexpensive through pharmacies. One syringe costs about 50 to 60 Som (US$0.05-0.06).

The UNDP/UNAIDS project has devised a questionnaire for IDUs to be administered on their first visit to the trust point. The questionnaire addresses such issues as frequency of drug use, types of drugs, preparation, administration of the drug, sharing of needles. A total of 300 questionnaires have been returned at the time of this assessment but no analysis had yet been done. Of note, the trust point visited in Fergana reported not using the questionnaire because they did not know how to administer it.

***Fergana:***

In Fergana City there are 190 registered drug addicts. Officials were hesitant to estimate the true number of IDUs but gave the number of about 600 IDUs in Fergana City. The officials indicated that females represent less than 5% of the IDU population. In the Fergana Oblast there are four major urban centers and 1,180 registered drug addicts, about 60% of whom are injecting drugs. Officials report that heroin is the main drug injected. One NGO from the Fergana Oblast supported by the ZdravPlus Project indicated that in a community survey using a written questionnaire, the community rated drug addiction as one of the three top problems in the community.

The city health department in September 2000 organized the trust point in Fergana City. It is staffed with 1 physician - a narcologist – and a nurse. A second trust point will be established in the oblast, in Kokand City. The trust point was advertised in the mass media and on radio. Meetings were organized with the AIDS center and the community. Finally doctors and nurses visited the homes of the registered IDUs to encourage/persuade IDUs and family members to attend the trust point. At the time of the interview at total of 48 had attended the trust point only once and 58 had attended the trust point more than once. There is on-going work with the police to ensure that the police do not harass visitors to the trust point. The officials in Fergana City indicated that they have very little data on IDU in Fergana, would like to know more and would like to do education work among IDUs. However, according to the officials, the IDU population is hard to access.

The main focus of NGOs in Fergana is training of health care providers and education of general population on reproductive health, hygiene, infectious diseases of children and nutrition. One

NGO deals with skill building among unemployed women; another has published an information newsletter on drug issues for the community. The NGO Ishonch has conducted over 300 seminars on reproductive health and STD and HIV issues for communities and youth groups.

***Yangi Yul:***
In Yangi Yul there are 129 registered drug users, 102 are IDU. The number of registered IDUs are increasing: in 1995 there were 18, 1996 there were 30, 1997 there were 41, 1998 there were 36 and in 1999 there were 59. Officials estimate that in reality there are at least ten time more IDUs than are actually registered, or over 1,000 IDUs in Yangi Yul. Among the 102 IDUs, 90 (88%) are male, all inject heroin, 88 (86%) are married and 96 (94%) are parents.

Two trust points have been established in Yangi Yul in September 2000. One is in a run down part of the city near an abandoned brick factory that was formerly a detention center with a dormitory. The second trust point, which is not used at all by the IDUs, is a city poly-clinic next door to the KGB building. At the time of the interview the trust points had distributed 900 syringes and over 120 condoms. As in Fergana, there was outreach to the registered IDU community encouraging them to use the trust point. In the beginning they indicated that only about 5 to 10% of the registered IDUs used the facilities. Now they estimate that about 30 to 40% of the registered IDUs use them. The trust point officials feel that they are not working enough with volunteers and are concerned that the syringes that they distribute might be sold instead of being used by the recipient. The trust point indicates that they are currently exchanging syringes for used ones (one-to-one exchange).

### *2. Female Sex Workers*

There appears to be very limited information on female sex workers in Uzbekistan and the focus of HIV prevention efforts for the moment appears to be on IDUs. The Deputy Minister of Public Health, Mr. Bakhtiyor Niyazmatov, indicated that HIV infection associated with FSW and transfusions was not of prime concern at the moment. There are 102 registered FSWs in Yangi Yul.

An assessment of the commercial sex industry in Tashkent was done in 1997 by UNAIDS. This report indicated that at the time of the report there were 180 registered FSWs in Tashkent but estimated that the actual number of FSWs was around 5,000. Six categories of sex workers were identified – street-based sex workers; hotel-based sex workers; bar/café sex workers, night-club/disco sex workers; sugar babies (women who are supported by one rich client at a time); and women working abroad as sex workers. This report highlighted the following issues in 1997 [Note – The determination of which of these issues are still relevant was not investigated during this assessment]:

- The mandatory HIV and STD testing and subsequent confinement if found infected deterred the FSWs from accessing the state run AIDS and STD services. Most sought care from private physicians.
- There were variable levels of accurate information regarding STDs and HIV infection, contraception and general reproductive health among the FSWs.

- The disease prevention properties of condoms were known among FSWs and condoms were readily available from kiosks, but were only affordable for some of the FSWs. The majority of clients refused condom use. When pimps were involved in the negotiation of price, the "contract" often did not include condom use.
- All FSWs interviewed had to pay "protection' money to police and/or other controllers of the sex industry and had to provide free sexual services to the police.

In Tashkent, a Soros funded NOG, SABO, started working with FSWs in 1999. The main activities include education on reproductive health and STDs, provide legal consultation and operate a telephone hotline. The total number of FSWs consulting the service to date is about 200. Of these 60% were Russian and 40% other. A total of 20% of them have children. The NGO is noting a trend towards younger and younger FSWs with many coming to the city from rural areas. The NGO also reports that there is violence against FSWs from police and clients.

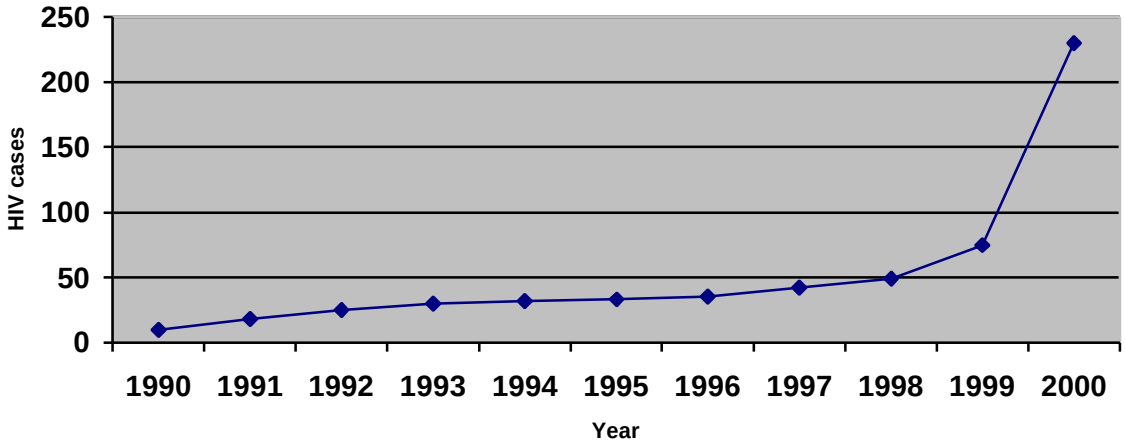
UNAIDS is supporting FSW assessments in several countries in the CAR. It is anticipated that some will be done in Uzbekistan in the year 2001.

### *3. HIV Situation*

As of the end of 2000 there have been 230 reported cases of HIV infection (Figure 4). A total of 80 of these cumulative cases have been identified from the City of Yangi Yul and 85 cases from Tashkent. The 80 cases in Yangi Yul have been epidemiologically associated with contact with persons from the Baltic States, Ukraine and Russia. The remaining oblasts with surveillance systems (there are a total of 14) have reported only a handful of cases, 2 to 4 per oblast. There has been a sharp upturn in cases after 1998, with the total number of cumulative cases less than 50 in 1998. A total of 79% of all HIV cases in Uzbekistan have been reported in the last two years. IDUs account for 72.5% of the reported HIV cases; about 14% have been attributed to heterosexual transmission and MSM accounts for about 3.1 %. In the remaining cases the risk is unknown. A total of 82.6% of the reported cases have occurred in males and 17.4% in females.

***A total of 79% of all HIV cases in Uzbekistan have been reported in the last two years. IDUs account for 72.5% of the reported HIV cases.***

**Figure 4: Registered HIV cases in Uzbekistan through 2000**




The current HIV surveillance system currently tests all blood donors; registered IDUs; STI patients; FSWs; persons with clinical signs; primary contacts of HIV infected persons; foreign citizens in the country for over three months; those requiring HIV infection certificates; and anonymous testing. All detainees in Uzbekistan are tested for HIV. If an HIV-infected person is subsequently imprisoned the HIV infected inmates are housed in specific facilities in Uzbekistan. This HIV testing is not handled through the MOH but rather the Ministry of Interior.

In the country as a whole, there were over 2 million tests performed. UNDP/UNAIDS is working with the government to rationalize the HIV testing strategy. Their approach is to focus testing on the high-risk groups – IDUs, CSW, MSM and youth. The UNDP/UNAIDS representative indicated that there is an inadequate supply of HIV reagents and that the locally produced tests had a high number of false positive results. The Deputy Minister of Public Health specifically requested assistance with laboratory equipment.

***Fergana:***
In the year 2000 the Fergana Oblast performed about 50,000 tests. There have been a total of 5 HIV infected cases identified in Fergana Oblast, 3 of which have died.

***Yangi Yul:***
The first HIV infected person in Yangi Yul was identified in May 1995. The person was from Russia who first presented with syphilis and was subsequently tested for HIV. In April 2000 a total 74 HIV infected persons were identified during regularly scheduled HIV surveillance testing. Of the total HIV infections in Yangi Yul 93% were identified in the last year. Of these 74 identified HIV infected persons, 67 (91%) were male and 9% were female. A total of 32 (43%) were classified as acquiring their HIV infection through IDU. Forty –two (57%) were classified as heterosexually acquired HIV infection. Note: On further questioning the head of the HIV/AIDS center indicated that the IDU transmission category is only attached to registered IDUs. He suspected that several of the heterosexually classified HIV infected persons were also IDUs. The age range of the HIV infected persons is as follows: 15 to 20 years – 3 persons; 21 to

30 years – 38 persons; 31-40 years – 30 persons; 41-50 years – 4 persons.

### *4. STD Situation*

Very limited information on STDs was obtained during this assessment visit due to limited time and the HIV focus of the assessment team. The Fergana officials indicated that syphilis and gonorrhea cases were decreasing in the oblast. In Uzbekistan has a whole, between 1990 and 1996 reported syphilis cases increased from 363 cases to 9,139 cases, a 25-fold increase. In 1998 there were 12,766 reported cases of syphilis and in 1999, 9,195 cases were reported.

### *5. Current HIV/AIDS Activities*

**UNAIDS/UNDP**

- Supporting HIV/AIDS strategy development and policy dialogue (The national strategic planning process is beginning this year and it is expected to take about two years.)
- Supports three trust points in Tashkent and provides technical assistance and initial tranche of needles to the 50 oblast level trust pointed established in 2000 through a decree.
- Provides technical assistance for HIV/AIDS prevention activities
- Provided training for health care providers
- Has supported assessment of IDU in Tashkent and FSW and MSM in Tashkent. Will be supporting FSW assessment in the year 2001.

**UNDCP**

- Supporting an upcoming comprehensive situational assessment of drug use in the five countries of central Asia.

**Soros/Uzbekistan**

- Supporting sex worker project in Tashkent.
- Supporting needle exchange project in Tashkent.

### *6. Summary Findings*

- There is little current information on the IDU situation in Uzbekistan.
- HIV transmission in Uzbekistan is overwhelmingly related to IDU and has rapidly increased in the last 2 years.
- While the government is supporting 50 trust points nationwide, from the two sites visited, it appears that government officials are having difficulty accessing the target communities. Current laws and official policies limit access to high-risk groups.
- There are NGOs in Fergana or in Yangi Yul working with IDUs and one working with FSWs in Tashkent.
- There is insufficient epidemiological investigation of identified HIV cases.
- Monitoring and evaluation strategies at the trust point-level, oblast-level and national level are not well articulated.
- There is little current information on commercial sex activities or interest in HIV prevention

in this setting
- Similar to the other CAR countries, syphilis prevalence increased rapidly in the 1990's.

## C. Kazakhstan

### *1. Drug Use, including IDU*

The prevalence of drug addiction in Kazakhstan sharply increased after 1991. The highest prevalence rates are observed in cities located along drug trafficking routes and cities and towns with a single industrial base. As a result of mine and factory closures after the breakup of the Soviet Union, many residents of these single industrial base towns such as Timertau were forced to migrate to Russia and Ukraine for employment. As the economic situation improved, many of them returned. It is thought that HIV infection in these cities was brought back with these returning economic migrants.

Injecting drugs used in the area are "khanka" (raw opium), "khimka", "koknar", "troyan", "shirka" or "shirevo" (opium derivatives), and heroin. Heroin is gradually replacing the traditional opiates in the drug market. The cost of the drugs is relatively inexpensive. Lower quality khanka and shirka can be purchased at US$1.5-$2.5 per gram in the central and northern Kazakhstan. Syringes of different quality are widely available, however, drug and syringe sharing is widely common (see Table 1).

The age of first drug consumption is decreasing. In the 1980s, first experience with smoking drugs occurred at the age of 16-18 years and regular consumption started at the age of 20-22 years. In the late 1990s, the age at first drug use was estimated to be 9-10 years of age with regular use starting at age 13-14 years.

***Kostanai:***

The city located in the north of Kazakhstan, 150 km from Russian border. Kostanai is located on one of the main north-south roads from the CAR. The Kostanai oblast government has organized two committees, one addressing IDU and one addressing drug control issues. The government plans to allocate $300,000 for drug issues (mainly law enforcement and improved treatment), as it is quite concerned about the high number of HIV cases in the oblast among IDUs. The Kostanai city administration has agreed to support a trust point site but the facility is not yet operational.

The NGO Public Fund Help has been working in harm reduction for almost two years. In addition to their harm reduction activities (described below) they also support a telephone hot line, consultations with a narcologist and psychologist, formative research and pre-and post-questionnaire evaluation. Additionally they have educational programs for teachers, parent and youth leaders on drug issues and support peer education among youth. They have also begun a street children program. Working with a sympathetic journalist the NGO was able to generate extensive coverage of drug issues through the print media in Kostanai.

The harm reduction program implemented by Public Fund Help has been supported by the Soros Foundation and has been operational for about 2 years. They currently have about 300 clients covered with their harm reduction services out of an estimated 3,000 to 4,000 in the city. The project now has four paid street outreach workers who work alone and has established two trust points in the city. Kostanai is quite spread out and it is difficult both for the IDUs to access the trust points and for the outreach workers to get to part of the city. Movement in the city is complicated by the extreme cold during winter. The project director would like to expand access and the above-mentioned city provided trust point would help in creating more service delivery points. The project director feels that in order for him to expand services the project would need a mobile van. The director felt that recruiting more volunteers would be difficult. To date no formative research has been done on the acceptability of a mobile van service to the IDU community or the surrounding neighborhoods where the van would be stopping. In addition to needle exchange the project provides disinfectant, counseling and education. The trust points also serve as a location where people can have blood drawn for anonymous HIV testing. The current services do not cover the area where the concentration of HIV infected IDUs have been identified.

Public Health Fund has collection baseline (service entry) and follow-up questionnaires after about 7 months using the service on about 160 clients. These questionnaires indicate decreasing risk behavior as illustrated below in Table 5.

**Table 5: Self-reported Behavior Change in 163 IDUs in Kostanai Harm Reduction Project**

| Risk/Protective Behavior | Baseline (n=163) % yes | Follow-up at 7 months (n=163) % yes |
|---|---|---|
| **Uses drugs more than once a day** | 64% | 59% |
| **Shares dose with the others** | 92% | 74% |
| **Uses somebody else's syringes (receptive sharing)** | 79% | 46% |
| **Uses disinfectants when washing syringes** | 11% | 67% |
| **Has adequate information about HIV/AIDS** | 21% | 58% |
| **Aware about situation in Timertau** | 28% | 87% |
| **Uses condoms?** | 22% | 59% |
| **Uses blood when preparing drugs?** | 9% | 2% |
| **Uses common instruments when preparing drugs?** | 73% | 68% |
| **Uses syringe over 5 times?** | 83% | 56% |
| **Uses syringe over 10 times?** | 64% | 12% |
| **Uses syringe over 20 times?** | 29% | 2% |
| **Boils syringes?** | 15% | 42% |
| **Uses syringe exchange point services all the time?** | 36% | 74% |
| **Checked oneself for HIV?** | 9% | 35% |

### *2. Female Sex Workers*

In general there are very little data on commercial sex in Kazakhstan, especially Northern Kazakhstan. Small overlaps have been documented between female commercial sex and IDU (see Table 1). Based on some UNAIDS supported ethnographic research, it appears that the sex work industry throughout most of the central Asian region is relatively unstructured. In Kostanai, there are no sex worker interventions and very little is known about the sex industry there. Given the proximity to Russia some features may be different than have been described further south, in Kyrgyzstan, for example.

### *3. HIV Situation*

Based on reported prevalence data in IDU populations the HIV epidemic situation in Kazakhstan using the UNAIDS classification is low level (and is possibly a concentrated epidemic (HIV prevalence is over 5% in high risk groups but less than 1% in general population) with high HIV prevalence in the IDU population in selected areas). In 1996 the Republic of Kazakhstan began

to see a dramatic increase in HIV infection over their previous reporting trend of (1-2 cases were reported annually). The first HIV+ case was registered in Kazakhstan in 1987. In June of 1996 a large number of HIV cases were reported in Karaganda oblast (city of Temirtau) that continued to increase in subsequent years such that 91% of the total registered HIV+ cases occurred in Karaganda oblast (see Table 6)

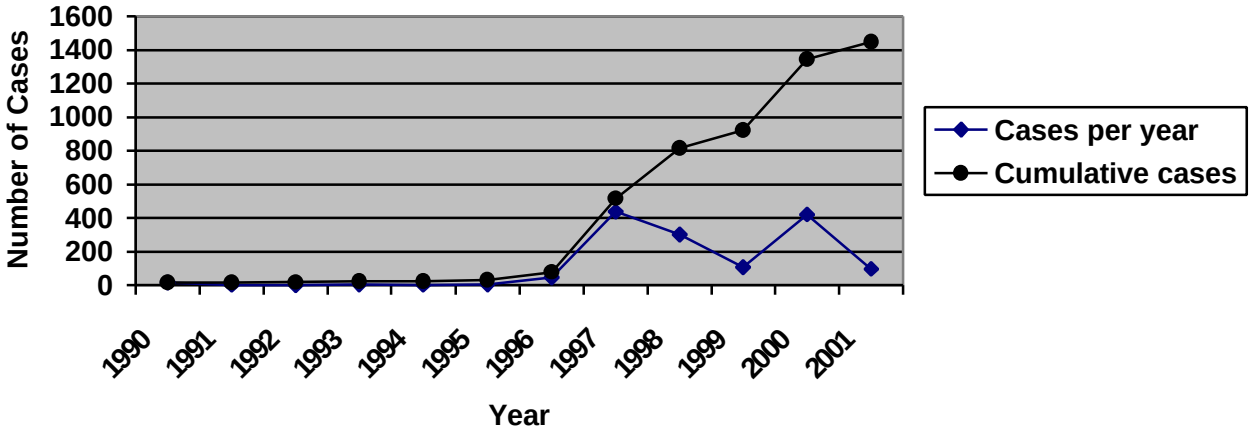
***Table 6. Distribution of HIV+ cases by oblast, Kazakhstan***
(1 January 1996 - 1 March 1998)

| Oblast | 1996 | 1997 | 1 March 1998 |
|---|---|---|---|
| **Akmolinskaya** | 1 | 4 | 6 |
| **Aktjubinskaya** | 0 | 0 | 2 |
| **Almatinskaya** | 0 | 1 | 4 |
| **Atyrauskaya** | 0 | 2 | 3 |
| **Eastern Kazakstan** | 0 | 3 | 3 |
| **Zhambylskaya** | 2 | 0 | 3 |
| **Western Kazakstan** | 3 | 3 | 6 |
| **Karagandinskaya** | 36 | 399 | 483 |
| **Kostanaiskaya** | 1 | 2 | 4 |
| **Kzylordinskaya** | 0 | 0 | 2 |
| **Mangistauskaya** | 0 | 2 | 3 |
| **Pavlodarskaya** | 1 | 2 | 5 |
| **North Kazakstan** | 0 | 10 | 13 |
| **South Kazakstan** | 2 | 10 | 13 |
| **city of Almaty** | 2 | 6 | 24 |
| **Republic of Kazakstan** | **48** | **437** | **566** |

As of January 1, 2001 a total of 1,347 HIV-infected individuals had been identified in Kazakhstan; 37 of them have AIDS. A total of 1,141 (84.7%) were attributed to IDU, 100 (7.4%) to heterosexual transmission, 8 (0.6%) to MSM and 92 (6.8%) are not established. A total of 925 (68.7%) occurred in the 15 to 29 year old age range and 282 (21%) in the 30 to 39 year old age range. The most dramatic increase in the number of HIV infections identified has occurred in the last two years (Figure 5).

***About 85% of the HIV infected cases in Kazakhstan can be attributed to IDU.***

**Figure 5: HIV infection in Kazakhstan**




Surveillance for HIV infection in Kazakhstan now targets the following groups: IDUs, convicts, blood donors, STI patients, pregnant women and patients with clinical indications. The issue of IDU in prisons and detentions centers was not assessed. However, Kazakhstan has introduced compulsory HIV testing of all accused held in detention centers. In the case where an HIV-infected detainee is convicted, he would be sent to an special prison for HIV infected people in Karaganda oblast.

Anonymous HIV testing is offered in all AIDS centers in all regions; however, epidemiological methods used by local officials do not encourage testing. Investigation of HIV infected individuals is sometimes performed by the so called 'doctor-police brigades'. The Kostonai Oblast HIV/AIDS coordinator described these brigades as a specific activity in the 2001 work plan.

***Kostanai:***

As of January 1, 2001 there were a total of 60 HIV cased identified in Kostanai oblast. A total of 53 of these cases were identified in 2000 and 51 of the 53 cases were attributed to IDU. Of these 60 cases, 73% are men and 26% are women. A total of 70% of the cases occurred in the 20 to 29 year old age range and 21% in the 30 to 39 year old age range. Eighteen of the 53 newly identified cases in 2000 were clustered in one neighborhood known to be populated with drug users.

The oblast AIDS center also has activities in training gynecologists and pediatricians in HIV care, education programs for school age children, teacher training programs (a total of 40 schools and 2,000 teachers were trained on HIV/AIDS in a 3 hour program). Last year the AIDS center held 5 events for youth. The HIV/AIDS center provides free anonymous HIV testing. Individuals who test positive are counseled and strong efforts are made to encourage HIV-infected individuals to reveal potential drug using and sexual contacts. The Ministry of Health and the Ministry of Interior now have a joint workplan that, in part, supports cooperation between the two ministries such that the police will provide protection to medical doctors or

nurses who track down and draw blood from IDUs and primary sexual contacts of HIV-infected persons. Last year, the Kostanai oblast tested 67,000 people (an increase of 32% from the year before attributed to increased testing supplies). Blood donors, IDUs, clinical indication, penitentiary inmates, foreign citizens, STI patients, pregnant women with risk factors and doctors are included in HIV testing and surveillance. The AIDS center indicates that HIV testing is being directed towards HIV risk groups. Sex workers and pimps who are registered with the police are followed up and tested for HIV.

The city council of Kostanai has approved supporting a third trust point in the city near the area with the concentration of identified HIV infected persons. The city will supply the room and the condoms and the NGO Public Health Trust will supply the syringes and the staff. This trust point is not yet operational.

### *4. STD Situation*

No information was gathered during this assessment of the STD situation in Kostanai or Kazakhstan. One UNAIDS reported noted a syphilis prevalence of 24% in FSWs in Shymkent in 1998.

### *5. Current HIV Prevention Activities*

The outbreak of HIV in Karaganda and Timertau cities mobilized a government response. As a result the National AIDS Center developed a national program plan for 1996-2000. This plan, however, has been insufficiently funded.

**UNAIDS/UNDP**
- Supporting HIV/AIDS strategy development and policy dialog. Approved strategy expected the first half of 2001.
- Supported RAR among drug users in Almaty, Polvadar, Astana and Shymkent and a situational assessment of commercial sex industry in Shymkent, Almaty, Taraz, Pavlodar, and Astana.
- Provides technical assistance for HIV/AIDS prevention activities.
- Provided training for health care providers.
- Supports pilot interventions in FSW in Shymkent and Almaty.
- Supports harm reduction interventions in Temirtau and South Kazakhstan oblast.

**UNDCP**
- Supporting an upcoming comprehensive situational assessment of drug use in the five countries of central Asia.

**Soros/Kazakhstan**
- Supports four harm reduction projects in Aktybinsk, Kostanai, Karaganda, Kzyl-Orda, Akmolinsk Oblast and Uralsk.
- Sponsored study tours to drug rehabilitation center and methadone center in Eastern Europe.
- Support for public advocacy and debate on drug policy.

- Supported HIV/AIDS hotline and mass media activities around drug use.

### *6. Summary Findings*

- Drug use and injecting drug use appear to be increasing dramatically in the country.
- Kazakhstan appears to have a low-level (nascent) HIV epidemic with pockets of HIV infection likely high enough to be classified as a concentrated epidemic.
- There is very small information about IDUs in penitentiary institutions.
- There is little surveillance data in the IDU populations outside of registered IDUs and other groups.
- There is some documentation that some female IDUs turn to commercial sex for income.
- Information on STDs in FSWs is extremely limited
- STD rates in IDUs are unknown.
- The reported practice of police/doctor squads tracing HIV infected drug users, their contacts and registered FSW is likely counterproductive.
- There is limited understanding of HIV and HIV prevention measures among some of the government and AIDS centers officials.
- In Kostanai, harm reduction intervention while showing behavior change is of an insufficient scale for significant impact. There are no interventions for FSWs and little information on them.

# IV. General Findings and Recommendations

## A. Findings

- Injecting drug use in the Central Asian Republics is increasing. Heroin appears to be displacing traditional opiates.
- HIV has now entered the IDU populations with documented small "outbreaks" of HIV infection in Kazakhstan and Uzbekistan. IDU account for
  - 72.5% of the 230 HIV cases in Uzbekistan
  - 71% of the 34 HIV cases in Kyrgyzstan (excluding the HIV infected Africans identified in early 1990s)
  - 84.7% of the1,347 HIV cases in Kazakhstan
- Based on the current information, the HIV epidemic in all three countries would be classified as a low-level (nascent) epidemic (defined as HIV prevalence under 5% in all groups) except for pockets where the epidemic is possibly concentrated (defined as HIV prevalence over 5% in any group but under 1% in the general population).
- HIV risk behavior in IDUs is high (e.g. needle sharing is common).
- The number of female IDUs is small but may be growing. A significant proportion of female IDUs engage in commercial sex.
- Syphilis and gonorrhea rates have been increasing from the early 1990's in all countries. In some they appear to be declining or stabilizing.

- All sites have varying policy and legal responses, and interventions of differing quality with target populations, access to the target populations and approaches. All of the current IDU intervention projects viewed during this assessment regardless of quality were of inadequate scale to have a significant impact on the HIV epidemic.
- NGO capacity for HIV/AIDS prevention intervention is limited in the region, although numerous talented, motivated and experienced people are in the region.
- Sex worker interventions were mature in Kyrgyzstan, just beginning in Kazakhstan (and there was no intervention in Kostanai), and not being considered in Uzbekistan. Projects to address clients of sex workers were very limited.
- The two most active donors were the UN agencies and Soros/Open Society Institute. Countries were allocating some of their budgets to HIV interventions.
- The countries collect a significant amount of HIV data, however this testing may not be giving an accurate picture of the epidemic in the high-risk populations. There are no systematic behavioral data collection activities and plans for evaluation of intervention projects are limited.

## B. Recommendations

**"Smart people learn from their own mistakes; wise people learn from other peoples'"**

**Anonymous**

HIV infection prevalence rates in the Central Asian Republics have only relatively recently begun to increase. This region is in the enviable position to learn from other countries' experiences and to act to avert a major outbreak of HIV infection. This sense of urgency was clear from the government officials interviewed. The UN Agencies and the Soros Foundation have begun the work of assisting governments in appropriate policy and strategy formulation for an effective response and have funded pilot projects for HIV prevention in these countries. The need now is to support the expansion of HIV prevention activities targeted at high-risk groups. While the responses are likely to be country specific initially, there is extensive movement of people between countries as well as drug traffic through the countries of the region. As such, cross border and regional strategies should be developed.

The Assessment Team recommends working to develop sustainable and effective capacity in an expeditious manner in order to reduce the incidence of HIV/AIDS. This will require strengthening existing individuals and institutions, and working to create and strengthen country and regional networks of groups working in HIV prevention. The areas of focus should be outreach and service delivery to vulnerable groups, personnel, organizational capacity development, information technology, communication, training, and education.

### *1. HIV in injecting drugs users:*

IDU is by far the most important mode of HIV transmission in the region. Injecting drug use is prevalent and increasing. There are substance abuse treatment centers and nascent harm reduction programs in every site visited. In addition to individual strengthening of each site (the needs vary considerably by site), these initiatives could benefit from a consolidated approach

within a behavior change framework that involves the full range of interventions aimed at reducing the spread of HIV. This includes the integration of drug use, sexual behavior, HIV VCT and HIV care and support.

While harm reduction interventions in existing IDUs should have the immediate priority for HIV prevention interventions, longer-term strategies for (1) assisting IDUs to stop injecting (substitution therapy, rehabilitation) and (2) preventing drug use in youth should be developed.

***Note:*** USAID's policy on harm reduction outlines restrictions and gives illustrative allowable activities for USAID funding. Restrictions deal mainly with funding for sterile injection equipment. When funds from other sources are used to fund program components that USAID does not support directly, USAID funds must be segregated and accounted for separately.

### *2. Prisons, HIV and TB*

The need for HIV/AIDS prevention interventions in regional detention centers and prisons should to be critically assessed. Detention centers and prisons put people at great risk of HIV/AIDS and other diseases because of (1) overcrowding which contributes to the climate of violence and tension and the spread of HIV and TB; (2) continued drug use by individuals in prison because of drug offenses – the atmosphere and the availability of drugs is not supportive in giving up drugs; (3) unsafe injecting practice because of the grouping of prisoners, the lack of mixing and injecting supplies and equipment and the lack of sterilizing equipment; (4) unprotected male-to-male sex and rape; (5) tattooing; skin piercing and blood brotherhood rites (frequency of tattooing, skin piercing and blood brotherhood rites in CAR prisons is unknown). Most people who are in prison will be released back into the community and any infectious disease contracted in prison can be passed to the non-prison population once a prisoner is released. Based on the high frequency of HIV infections in other prison settings globally, HIV prevention programming is warranted.

The grouping of HIV positive prisoners in Kazakhstan and Uzbekistan has implications for TB control in these populations. HIV infection increases the risk of re-activation of latent TB to active disease. A person with HIV and TB has a 30 to 50% chance of developing active TB disease. Moreover, in HIV infected persons, a primary TB infection is more likely to rapidly develop into TB pneumonia with a high transmission rate and high mortality rates. Because of this HIV-TB synergy, TB control programs should consider (1) active TB case finding in HIV infected prisoners and (2) TB prophylactic treatment in those without active disease.

### *3. Sex workers and Their Clients*

Attention to commercial sex work is just beginning in the central Asian republics (two well-functioning interventions exist in Kyrgyzstan, two new interventions in Kazakhstan, and one in Uzbekistan). Sex workers and their clients represent an important risk group for the spread of HIV and other STDs into the general population. Given the reported high prevalence of STDs in this group, albeit limited information, and the overlap between IDU and sex work, HIV prevention interventions with sex workers and clients is critical to a long term HIV prevention

strategy in the CAR. Addressing the IDU-commercial sex overlap requires utilizing the better practices of two separate "disciplines" in HIV prevention. Interventions for FSW should include outreach, condoms promotion, STD treatment services, linkages with other services (e.g. harm reduction, HIV VCT), and advocacy to address legal and political barriers to HIV prevention. Work with police forces of these countries is warranted.

### *4. STD issues*

The variance in rates of partner change within populations greatly influences the rates of spread of STD. Individuals with the highest rates of partner change disproportionately increase the rate of spread of STDs within the population. Thus STD interventions should have the greatest impact if they are effectively focused and delivered among individuals who have many partners and in dense sexual networks. To the extent that interventions provided through public and private sectors do not reach such populations, the impact on STD spread in the population may be quite limited. Two examples of where targeted STD interventions in sex workers have reduced general population STD levels are Thailand and South Africa.

The reported high levels of syphilis and gonorrhea in sex workers in Bishkek, Kyrgyzstan, are likely representative of FSW populations in the region. These STD prevalence levels warrant aggressive outreach and appropriate STD service delivery to these women as a response to the epidemic of STDs in the region. Targeting high-risk men through workplace programs (e.g. uniformed services) would be a supplemental intervention to address the STD epidemic. Prevalence rates of other STD pathogens (e.g. *C. trachomatis*) and STD rates in other high risk and vulnerable populations are unknown in the CAR. This information would be extremely valuable in directing appropriate resource and interventions at key groups. Current STD educational efforts directed at general population are likely having minimal to no impact on STD prevalence rates in the region.

### *5. Surveillance*

The majority of HIV/AIDS data in CAR is obtained from extensive routine testing of registered individuals in defined risk groups; from anonymous testing sites; routine testing of prisoners and detainees; and routine testing of blood donors and other lower risk populations. There is no systematic behavioral data collection in high-risk groups with which to track risk behaviors and limited HIV/STD prevalence data to monitor and adjust programming. New, strengthened surveillance systems, dubbed "second generation surveillance systems" aim to concentrate resources where they will yield information that is more useful. (Note: the quality of the locally available HIV test and the reliability of the laboratory equipment was a consistent theme at all sites. Laboratory issues were not investigated in this assessment.)

As with any disease surveillance system, the purpose of surveillance in the area of HIV/AIDS, STDs and related behaviors is to give support to public health activities. The specific roles of the Central Asian surveillance systems for HIV/AIDS, STDs and related behaviors would be four-fold:

- *Advocacy*: provide information that can be used to raise awareness of policy makers, funding bodies and other relevant organizations, as well as the media and the general public, about the public health importance of HIV/AIDS and STDs.
- *Situation assessment*: provide ongoing estimation of the past and current trends of behavior, transmission of HIV and other STDs, to guide the development and implementation of intervention programs.
- *Planning*: inform the planning of health services for both prevention and care, by providing estimates and projections of numbers of people at risk of infection and numbers of people requiring clinical treatment.
- *Evaluation*: provide the basis for assessing the overall impact of intervention programs in reducing the transmission rates of HIV and other STDs and in reducing the burden of illness resulting from these infections.

Recommendations for HIV related surveillance in Central Asia Republics, a low-level epidemic, would include the following:

- Cross-sectional surveys of behavior in sub-populations with risk behavior (IDUs, sex workers, MSM, high risk men?).
- Surveillance of STDs and other biologic markers of risk.
- HIV surveillance in sub-populations at risk.
- HIV and AIDS case reporting.
- Tracking of HIV in donated blood.
- Cross sectional surveys of behavior in general population of youth (less frequently than sub-populations with known risk behavior).

It is recommended that several underlying principles be respected in the design and implementation of an HIV/AIDS and STD surveillance system:

- *Support for national program*: All activities should be carried out under the guidance of the National AIDS Center to ensure maximum support of the program.
- *Scientific validity*: The activities should be based on the best available scientific methodologies over time.
- *Capacity building*: Appropriate training should be provided at all levels so that national institutions can conduct the surveillance as autonomously as possible.
- *Consistency*: The activities should be standardized over time as far as possible, to allow for valid assessment of time trends and geographic patterns.
- *Confidentiality and informed consent*: All activities should respect individual rights and ensure confidentiality regarding health and medical status. Informed consent for participation in surveillance activities should be assured unless using some forms of unlinked anonymous methods are used (e.g. stripping identifiers off of already collected specimens).
- *Acceptability*: Activities must be acceptable to all people involved in the surveillance, including the subjects.
- *Coordination*: Integration of all agencies involved in HIV/AIDS activities is necessary to

assure collection of the maximum amount of data.

### *6. Research*

Behavioral data and formative research will need to be done as part of expanding and strengthening current interventions for IDUs, FSWs and potentially other target groups. As a first step in a program development cycle, information should be collected to describe the current situation, identify needs, and orient an effective response. A situation analysis should consider available data on the target behavior or disease prevalence and incidence, capacity and quality of existing services, current use of those services, as well as access and acceptability issues from the perspective of the target population. This information is critical to designing good quality programs and the collection of the information should be linked with intervention projects. The meetings and interviews that comprise formative research activities should be seen as important opportunities to promote trust and participation of key target populations, especially given the difficulty in accessing these groups; these activities are ideally implemented by groups who will ultimately provide services.

### *7. Information dissemination/BCC materials*

The adequate exchange of information, skills, perspectives and knowledge at the project and grassroots levels is important. It is suggested that an inventory or some other systematic collection of information on expertise and literature available in the region be performed. The inventory could include:

- Information on organizations, programs and services that are either aimed at target populations or will be needed for effective HIV prevention and care among the target populations;
- Cataloguing educational material that has been produced regionally and in Russian from the NIS; and
- Developing a database of practitioners.

This documentation exercise could also help identify promotional and educational materials that could be used by several organizations as to avoid duplication of efforts. Other materials could be produced as a joint initiative among groups and countries. For instance, the inventory process could lead to the production of an 'Annotated Bibliography' of the available materials. High quality materials could be translated into the necessary local languages and disseminated in printed and electronic forms.

This information should be readily accessible and can be aided by the recently created Central Asian Harm Reduction Network.

### *8. Capacity Development*

Some technical capacity and informal networks already exist in the CAR region. However, there is a need for a structured and ongoing technical support mechanisms that would further develop the capacity of individuals and organizations to design and implement HIV prevention programs for high risk groups within a comprehensive behavior change interventions framework. Among the knowledge and skills that need to be strengthened are:

- HIV prevention implementation skills – strategy, design, report writing, implementation approaches and management and organization skills. This can be accomplished through technical assistance, NGO "twinning", national and regional workshops to increase skills, and participation in international meetings and other fora.
- Participatory planning to ensure participation of target populations in the design and implementation of programs;
- Establishment of client friendly services for at risk populations, especially those that foxus on at STD case management, family planning (including for HIV positive individuals and discordant couples) and HIV VCT;
- Strengthening formal linkages and referral systems to services (especially STDs, family planning, HIV VCT, TB and HIV care and support);
- Comprehensive behavior change intervention programming for IDUs that more effectively integrate drug issues, sexual behavior, HIV VCT and HIV care and support;
- The continuum of counseling from community-based peer counseling to HIV VCT to professional-led sexual and substance use/abuse counseling; and
- Monitoring and evaluation and the use of data for programming and advocacy.

Additionally, the training of local and regional technical support providers will facilitate the strengthening of other organizations and programs. Some individuals are already providing assistance to other organizations in the region, but there is a need to expand this technical assistance base and unify concepts among are to ensure consistency in the delivery of technical support. Selecting individuals or institutions that are strong and further developing their capacity to deliver technical support in the priority areas described above could achieve this. The training of technical support providers can be done in stages that go from values clarification and state-of-the-art approaches, to delivery of technical support, monitoring and evaluation.

### *9. Donor communication/coordination*

Creating a forum for communication among donors provides an opportunity for those working to reduce the spread HIV/AIDS to better meet the needs of the central Asian countries. Such communication and coordination can identify gaps in services, duplication of efforts, and potential areas for collaboration, as well as head-off potential cross activities that might hinder the activities' successes. In order to avoid this duplication of efforts and encourage coordination, there needs to be regular communication among donors.

# V. References and Resources

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# VI. Contact List

| Name | Address | Phone/FAX/e-mail |
|---|---|---|
| Dr. Gina Dallabetta<br>Team Leader | Family Health International<br>2101 Wilson Boulevard<br>Suite 700<br>Arlington, VA 22201 | Phone: +7 (703) 516-9779<br>FAX: +7 (703) 516-9781<br>Gdallabetta@fhi.org |
| Mr. Sergey Gavrilin<br>Consultant | 254/37 Chokmorov St.<br>Bishkek, Kyrgyzstan | Phone: +996 (312) 254021<br>Sergey_g@hotmail.kg |
| ***Kazakhstan*** | | |
| Mr. Gerry Fernandez<br>Ms. Jennifer Adams<br>Ms. Sheri Collins<br>Mr. Glenn Anders,<br>Mission Director | USAID/CAR Regional Mission<br>97A Furmanov St.<br>Almaty 480091<br>Kazakhstan | Phone +7 (3272) 507634, 507617, 507677<br>FAX +7 (3272) 507636, 696490, 507633<br>Gfernandez@usaid.gov |
| Ms. Grace Hafner<br>Director Public Health Programs | ZdravPlus<br>Zhibek Zoly 60, Apt.7<br>480002, Almaty<br>Republic of Kazakhstan | Phone: +7 (3272) 335687, 337647, 332755<br>FAX: +7 (3272) 335670<br>ghafner@zreform.almaty.kz |
| Dr. Turar E. Chaklikov<br>General Director | Republic Centre for AIDS Prevention and Control<br>Ministry of Health,<br>Republic Kazakhstan<br>84, Auezov Street,<br>Almaty, 480008<br>Republic of Kazakhstan | Phone +7 (3272) 53-97-13<br>FAX +7 (3272) 50-92-62<br>rc@aids.ricc.kz |
| Ms. Valeriya Gurevich<br>Public Health Coordinator<br>Fund Raising Manager | Soros Foundation, Kazakhstan –<br>117-20 Furmanova Street, 480091<br>Almaty, Kazakhstan | Phone: +7 (3272) 503-811<br>FAX +7 (3272) 503-814<br>vgourev@soros.kz |
| Mr. Gustavo Angeles<br>Deputy Director | MEASURE Evaluation<br>Carolina Population Center<br>University of North Carolina at Chapel Hill<br>CB#8120 University Square East<br>Chapel Hill, NC 27516-3997 | Phone (919) 966-7482<br>FAX (919) 966-2391<br>Gustavo_Angeles@unc.edu |

| Name | Address | Phone/FAX/e-mail |
|---|---|---|
| Dr. Rudick Adamian<br>UNAIDS Intercountry Programme Advisor for C.A.R. | UNAIDS<br>UN Office, 67, Tole Bi Street<br>Almaty, 480091<br>Kazakhstan | Phone +7 (3272) 627444, 582643, 582646<br>FAX +7 (3272) 582645, 505907<br>rudik.adamyan@undp.org |
| Dr. Alexander Kossukhin<br>Coordinator of Integrated Programme of Healthy Lifestyle Development | UNDP<br>67 Tole Bi Street<br>Office 201<br>Almaty 480091<br>Kazakhstan | Phone +7(3272)582643, ext 221<br>FAX +7(3272) 582645, 505745<br>Alexander.kossukhin@undp.org |
| Mr. Michael O. Favorov<br>CDC Central Asia Program Director | CDC<br>91/97 Furmanova Street<br>Apt 15<br>Almaty, Kazakhstan 480009 | Phone/FAX (3272) 63-86-57<br>mfavorov@usaid.gov |
| Dr. Igor Vasilenko<br>Director | Public Fund "Help"<br>67,5 April Street<br>Kostanai<br>Kazakhstan | Phone +7 (3142) 533555, 549226<br>ngokist@krcc.kz |
| Dr. Armash K. Yesinzholov<br>Chief Doctor | Kostanai Oblast AIDS Center | Phone +7 (3142) 531900 |
| Deputy Mayor, Kostonai Oblast | | |
| ***Kyrgyzstan*** | | |
| Ms. Tatiana Dementyeva | USAID/CAR Country Office<br>171 Prospect Mira<br>Bishkek<br>Kyrgyzstan | Phone: +996 (312) 55-12-41<br><br>tdementyeva@usaid.gov |
| Dr. Yves Marchandy<br>Head of Mission/Medical Coordinator<br><br>Ms. Rumi Inoue<br>Coordinator of Prevention Program | Medecins Sans Frontieres<br>Leningradskaya Str.<br>Osh City, 714000<br>Kyrgyzstan | Phone +996 (3222) 5-72-15.<br>FAX: +996 (3222) 5-70-52<br>msffosh@infotel.kg |

| Name | Address | Phone/FAX/e-mail |
|---|---|---|
| Ms. Elmira Imambakieva<br>Coordinator of Youth Programs<br><br>Ms. Fatima Koshokova<br>Prevention Program Assistant | "Rainbow"<br>Leningradskaya Str. 1 A<br>Osh City, 714000<br>Kyrgyzstan | Phone +996 (3222) 2-17-92<br>FAX +996 (3222) 2-70-52<br>rainbow@infotel.kg |
| Dr. Mamasobir Burkhanov<br>Chief Narcologist, | Isanov St., Oblast Narcology Dispensary<br>Osh<br>Kyrgyz Republic | Phone/FAX +996 (3222) 5-47-59<br>Burkanov@infotel.kg |
| Dr. Tugelbay M. Mamaev<br>Chief Doctor | Osh Oblast Center on AIDS Prevention<br>10, Mominova Street<br>Osh<br>Kyrgyz Republic | Phone +996 (3222) 7-76-30<br>+996 (3222) 7-76-10<br>FAX +996 (3222) 5-71-34<br>Home +996 (3222) 6-53-31 |
| Dr. Boris Shapiro<br>General Director | Kyrgyzstan Republican AIDS Center<br>8, Logvinenko Str.<br>Bishkek<br>Kyrgyzstan | Phone/FAX +996 (312) 227290 |
| Ms. Gulnara Kurmanova<br>Psychologist | American University<br>Department of Psychology<br>205 Abdymomunova Street<br>Bishkek, Kyrgyzstan | Phone (996) 312 66 10 92<br>FAX (996) 312 66 32 01<br>kurmanova@netmail.kg |
| ***Uzbekistan*** | | |
| Dr. Alisher Ishoaov<br>Health Assistant<br><br>Ms. Cheri Vincent<br>Health Project Management Specialist | USAID/CAR Country Office<br>Shark Building, 4th Floor<br>41 Buyuk Turon Street<br>Tashkent, Uzbekistan | Phone (998) 71 120-63-09<br>FAX: (998) 71 133-76-56<br>alisher@usaid.uz<br>cheri@usaid.uz |
| Mr. Bakhtiyor I. Niyazmatov<br>Deputy Minister of the Ministry of Public Health | Ministry of Public Health<br>The Republic of Uzbekistan<br>No. 12 Navoi Street<br>Tashkent, 700011 | Phone 52-83<br>41-16-24 |
| Ms. Melinda Pavin<br>Fergana Site Manager/ Evaluation Specialist | Abt Associates<br>¾, Komus Street, 1a,<br>712000<br>Fergana<br>Republic of Uzbekistan | Phone (3732) 24 49 64,<br>24 93 53, 24 76 56, 24 88 76<br>FAX (3732) 24 76 56<br>abt@vodiy.uz |

| Name | Address | Phone/FAX/e-mail |
|---|---|---|
| Mr. Bulat Kumaev<br>Project Manager<br>Project UZB 99/014<br>(HIV/AIDS) | UNDP<br>Chilanzar 16<br>Building 12<br>Tashkent, 700135<br>Uzbekistan | Phone/FAX:<br>(998-71) 1207353<br>bulat@uzsci.net |
| Dr. Mumtoz Khakimov<br>Director, Republican<br>AIDS Center | Chilanzar 16<br>Building 12<br>Tashkent, 700135<br>Uzbekistan | Phone: 120-7353 |
| Dr. Nizom Xayrullaevich<br>Abullaev | Yangi Yul | Phone (37160) 2-27-01, 5-65-33 |
| Tamara G. Tokmakova<br>Director | Oblast AIDS Center | |
| Zulphiya Akhunova –<br>Director | NGO “Ishonch”Fergana<br>Oblast Center Of Social<br>And Legal Support Of<br>Women And Teenagers | Phone/Fax 373-2 24-90-44<br>ishonch@vodiy.uz |